SERFF Tracking Number:	*MNNL-126770349*	*State:*	*Arkansas*
Filing Company:	*Minnesota Life Insurance Company*	*State Tracking Number:*	*46510*
Company Tracking Number:	*MHC-999*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Applications*		
Project Name/Number:	*Individual Life Applications/MHC-999*		

Filing at a Glance

Company: Minnesota Life Insurance Company

Product Name: Individual Life Applications	SERFF Tr Num: MNNL-126770349	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 46510
Sub-TOI: L08.000 Life - Other	Co Tr Num: MHC-999	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Carol Ouhl, Susan Johnson, Matthew Harrington, Joyce Townsend	Disposition Date: 08/18/2010
	Date Submitted: 08/16/2010	Disposition Status: Approved-Closed
Implementation Date Requested: 09/16/2010		Implementation Date:

State Filing Description:

General Information

Project Name: Individual Life Applications	Status of Filing in Domicile: Authorized
Project Number: MHC-999	Date Approved in Domicile: 07/10/2010
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 08/18/2010	Explanation for Other Group Market Type:
	State Status Changed: 08/18/2010
Deemer Date:	Created By: Joyce Townsend
Submitted By: Joyce Townsend	Corresponding Filing Tracking Number: MHC-999

Filing Description:

RE: INDIVIDUAL LIFE APPLICATIONS AND QUESTIONNAIRES

This filing contains 26 applications and corresponding forms occasionally required in the application process. These forms are new and do not replace any previously approved forms.

SERFF Tracking Number:	*MNNL-126770349*	*State:*	*Arkansas*
Filing Company:	*Minnesota Life Insurance Company*	*State Tracking Number:*	*46510*
Company Tracking Number:	*MHC-999*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Applications*		
Project Name/Number:	*Individual Life Applications/MHC-999*		

These applications will be used in both paper and electronic formats. Security on and verification of electronic data is handled through an outside vendor, iPipeline. Electronic signature is applied via the use of "Accept" and "Decline" buttons which become active upon the completion of reading the Terms and Conditions Disclosure. I have attached to the Supporting Document tab a brief description of the iPipeline process.

Statement of types: These application forms will be used to apply for any one, or a multiple of, the products available in the entire portfolio we offer which consists of Individual Life products listed below.

Term Life, Advantage Elite Term, form 07-400, approved 03-28-2007, DOI #35380
Term Life, Advantage Annual Renewal Term, form MHC-470, approved 11-12-98, No DOI #
Term Life, Advantage Annual Renewal Term Second Death, 99-460, appvd 11-15-1999, no DOI #
Whole Life, Secure Whole Life, form 09-110.03, approved 05-15-2009, DOI #42184
Universal Life, Adjustable Life Legend, form 07-650, approved 02-13-2008, DOI #37969
Universal Life, Adjustable Life Summit, form 02-630, approved 01-21-2003, DOI #21321
Universal Life Second Death, Legacy Protector Survivorship, 08-210.03, apprvd 10-14-08,#40431
Indexed Universal Life, Eclipse, form 06-700, approved 07-07-2006, DOI #32713
Indexed UL Second Death, Eclipse Protector, form 09-710.03, approved 12-01-2009, DOI #43942
Variable Life, Variable Adjustable Life Horizon, form 99-680, approved 04-12-2000, no DOI # given
Variable Universal Life, Variable Adjustable Life Summit, form 03-640, appvd 10-04-03, DOI#24045
Variable UL, Minnesota Life Accumulator, form 07-660, approved 05-25-2007, DOI #35938
Variable UL, Waddell & Reed Accumulator, form 07-660W, approved 11-26-2007, DOI #37355

Thank you for your consideration.

Company and Contact

Filing Contact Information

Joyce Townsend, Senior Product Compliance Specialist	joyce.townsend@securian.com
400 ROBERT STREET NORTH	651-665-5902 [Phone]
ST. PAUL, MN 55101-2098	651-665-5424 [FAX]

Filing Company Information

Minnesota Life Insurance Company	CoCode: 66168	State of Domicile: Minnesota
400 Robert Street North	Group Code: 869	Company Type:
Law Department	Group Name:	State ID Number:
St. Paul, MN 55101-2098	FEIN Number: 41-0417830	
(651) 665-3500 ext. [Phone]		

SERFF Tracking Number:	*MNNL-126770349*	*State:*	*Arkansas*
Filing Company:	*Minnesota Life Insurance Company*	*State Tracking Number:*	*46510*
Company Tracking Number:	*MHC-999*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Applications*		
Project Name/Number:	*Individual Life Applications/MHC-999*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$1,300.00
Retaliatory?	No
Fee Explanation:	$50 x 26 forms
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Minnesota Life Insurance Company	$1,300.00	08/16/2010	38798235

SERFF Tracking Number:	*MNNL-126770349*	*State:*	*Arkansas*
Filing Company:	*Minnesota Life Insurance Company*	*State Tracking Number:*	*46510*
Company Tracking Number:	*MHC-999*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Applications*		
Project Name/Number:	*Individual Life Applications/MHC-999*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/18/2010	08/18/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Description of IPipeline Process	Joyce Townsend	08/17/2010	08/17/2010

SERFF Tracking Number:	*MNNL-126770349*	*State:*	*Arkansas*
Filing Company:	*Minnesota Life Insurance Company*	*State Tracking Number:*	*46510*
Company Tracking Number:	*MHC-999*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Applications*		
Project Name/Number:	*Individual Life Applications/MHC-999*		

Disposition

Disposition Date: 08/18/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MNNL-126770349*	*State:*	*Arkansas*
Filing Company:	*Minnesota Life Insurance Company*	*State Tracking Number:*	*46510*
Company Tracking Number:	*MHC-999*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Applications*		
Project Name/Number:	*Individual Life Applications/MHC-999*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Description of IPipeline Process		Yes
Form	Individual Life Insurance Amendment of Application and Certificate of Insurability		Yes
Form	Individual Life Insurance Aviation Risk Exclusion Rider		Yes
Form	Military/Aviation Statement		Yes
Form	Individual Life Insurance Application		Yes
	Family Term Agreement - Child/Additional Insured/Children's Term Agreement		
Form	Individual Life Insurance Certificate of Good Health		Yes
Form	Individual Life Insurance Sports and Avocations Statement		Yes
Form	Individual Life Insurance Ownership Endorsement		Yes
Form	Chemical Use Questionnaire		Yes
Form	Individual Life Insurance Supplement to Application Part 1 Variable Adjustable Life Survivor		Yes
Form	Individual Life Insurance Home Office Corrections or Additions		Yes
Form	Individual Life Insurance Application Part 1		Yes
Form	Individual Life Insurance Policy Change Application Part 3 (Underwriting) Agreements and Authorizations		Yes
Form	Individual Life Insurance Application Part 3 Agreements and Authorizations		Yes
Form	Individual Life Insurance Policy Change Application No Underwriting		Yes
Form	Individual Life Insurance Policy Change Application Part 1 Underwriting Required		Yes
Form	Individual Life Insurance Life Receipt and Temporary Insurance Agreement		Yes
Form	Individual Life Insurance Life Receipt and		Yes

SERFF Tracking Number:	*MNNL-126770349*	*State:*	*Arkansas*
Filing Company:	*Minnesota Life Insurance Company*	*State Tracking Number:*	*46510*
Company Tracking Number:	*MHC-999*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Applications*		
Project Name/Number:	*Individual Life Applications/MHC-999*		

	Temporary Insurance Agreement For Joint Life Products	
Form	Individual Life Insurance Home Office Corrections or Additions	Yes
Form	Individual Life Insurance Application Part 1	Yes
Form	Individual Life Insurance Beneficiary Change Acknowledgement	Yes
Form	Individual Life Insurance Financial Supplement to Application	Yes
Form	Individual Life Insurance Application 1A	Yes
Form	Individual Life Insurance Application Part 1B	Yes
Form	Supplemental Information to the Application for Life Insurance	Yes
Form	Individual Life Insurance Life Receipt and Temporary Insurance Agreement	Yes
Form	Individual Life Insurance Application Part 2	Yes

SERFF Tracking Number:	*MNNL-126770349*	*State:*	*Arkansas*
Filing Company:	*Minnesota Life Insurance Company*	*State Tracking Number:*	*46510*
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Product Name:	*Individual Life Applications*		
Project Name/Number:	*Individual Life Applications/MHC-999*		

Amendment Letter

Submitted Date: 08/17/2010

Comments:

I neglected to attach the IPipeline Process description. I have attached this to the Supporting Documents tab. I apologize for the confusion.

Joyce Townsend

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Description of IPipeline Process

Comment: Attached is E-Signature Process Description.

E-Signature Process Descrip.pdf

SERFF Tracking Number:	*MNNL-126770349*	*State:*	*Arkansas*
Filing Company:	*Minnesota Life Insurance Company*	*State Tracking Number:*	*46510*
Company Tracking Number:	*MHC-999*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Applications*		
Project Name/Number:	*Individual Life Applications/MHC-999*		

Form Schedule

Lead Form Number: MHC-999

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FMHC-999 Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Amendment of Application and Certificate of Insurability	Initial		51.900	MHC-999 Rev 5-2010 Amend App Cert Ins ns.pdf
	FMHC-4482 Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Aviation Risk Exclusion Rider	Initial		52.800	MHC-4482 Rev 5-2010 Aviation Risk ns.pdf
	FMHC-4883 10-1998	Application/ Enrollment Form	Military/Aviation Statement	Initial		60.200	MHC-4883 ns.pdf
	09-9415 Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Application Family Term Agreement - Child/Additional Insured/Children's Term Agreement	Initial		50.000	09-9415 5-2010 Children-Family Term App final ns.pdf
	FMHC-10202 Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Certificate of Good Health	Initial		53.900	MHC-10202 Rev 5-2010 Cert of Good Hlth ns.pdf
	FMHC-11393 Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Sports and Avocations Statement	Initial		63.500	MHC-11393 5-2010 Sports Avocation ns.pdf
	FMHC-14426 Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Ownership Endorsement	Initial		53.200	MHC-14426 5-2010 no sec.pdf

FMHC-41395 Rev 5-2010	Application/ Enrollment Form	Chemical Use Questionnaire	Initial	57.400	MHC-41395 Rev 5-2010 Chem Use Quest ns.pdf
FMHC-43186V Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Supplement to Application Part 1 Variable Adjustable Life Survivor	Initial	57.400	MHC-43186V 5-2010 App Suppl VAL ns.pdf
F44490 Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Home Office Corrections or Additions	Initial	53.800	44490 Rev 5-2010 HO Correct Addns ns.pdf
F59410 Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Application Part 1	Initial	54.100	59410 Rev 5-2010 Pt 1 Issue ns.pdf
F59534 Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Policy Change Application Part 3 (Underwriting) Agreements and Authorizations	Initial	52.200	59534 R5-2010 Pt 3 Policy Change w U-W final ns.pdf
F59536 Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Application Part 3 Agreements and Authorizations	Initial	50.200	59536 5-2010 Pt 3 - Issue final ns.pdf
F59537 Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Policy Change Application No Underwriting	Initial	53.600	59537 5-2010 Policy Change no U-W final ns.pdf
F59538 Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Policy Change Application Part 1 Underwriting Required	Initial	50.100	59538 5-2010 Pt 1 Policy Change w U-W ns.pdf
F59796 Rev 5-2010	Application/ Enrollment	Individual Life Insurance Life	Initial	53.600	59796 5-2010 Life Rec and

	Form	Receipt and Temporary Insurance Agreement				TIA no sec.pdf
F59797 Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Life Receipt and Temporary Insurance Agreement For Joint Life Products	Initial		51.500	59797 Rev 5-2010 Life Receipt TIA-Jnt Life ns.pdf
F64347 Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Home Office Corrections or Additions	Initial		58.700	64347 Rev 5-2010 HO Correct Addn ns.pdf
F65324 Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Application Part 1	Initial		52.700	65324 Rev 5-2010 Pt 1 IDG ns.pdf
F65915 Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Beneficiary Change Acknowledgement	Initial		53.200	65915 5-2010 Bene Acknowledge in Pol.pdf
F66046 Rev 5-2010	Application/ Enrollment Form	Individual Life Insurance Financial Supplement to Application	Initial		61.400	66046 Rev 5-2010 Financial Suppl to App ns.pdf
F72540 3-2010	Application/ Enrollment Form	Individual Life Insurance Application 1A	Initial		50.500	72540 3-2010 Quick App 1A ns.pdf
F72541 3-2010	Application/ Enrollment Form	Individual Life Insurance Application Part 1B	Initial		61.800	72541 3-2010 Quick App 1B ns.pdf
F72587 4-2010	Application/ Enrollment Form	Supplemental Information to the Application for Life Insurance	Initial		53.800	72587 4-2010 Suppl to Pt 2.pdf
F59798 Rev 6-2010	Application/ Enrollment Form	Individual Life Insurance Life Receipt and	Initial		52.400	59798 Rev 6-2010 Life Receipt and

SERFF Tracking Number:	*MNNL-126770349*	*State:*	*Arkansas*
Filing Company:	*Minnesota Life Insurance Company*	*State Tracking Number:*	*46510*
Company Tracking Number:	*MHC-999*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Applications*		
Project Name/Number:	*Individual Life Applications/MHC-999*		

		Temporary Insurance Agreement			TIA Pol Chng ns.pdf
F59573-T 6-2010	Application/ Enrollment Form	Individual Life Insurance Application Part 2	Initial	50.500	59573-T 6-2010 App Pt 2 Tele ns.pdf

Individual Life Insurance
Amendment of Application and Certificate of Insurability

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Name	Application date	Policy number

The above described application is hereby amended as follows:

Please complete any questions asked below, giving DETAILS.

To the best of your knowledge and belief, since the above date, has any person insured under this application:

1. ☐ Yes ☐ No experienced any change as to health, occupation, or other conditions or insurability; or
2. ☐ Yes ☐ No suffered or sustained any disabling accident or injury or lost any time from occupation or employment because of accident or sickness; or
3. ☐ Yes ☐ No consulted or been treated by any doctor on account of sickness or injury; or
4. ☐ Yes ☐ No been refused insurance by any company?

If any questions answered "Yes," give details below.

Declarations made in this amendment are to be taken and considered a part of said application.

Date	Firm/rep	Signature of insured X
Witness - representative X		Signature of applicant X

Firm/Rep:

OP-ID:

Individual Life Insurance
Aviation Risk Exclusion Rider

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

The liability of the Company under this policy shall be limited as hereinafter provided, if the Insured dies as a direct or indirect result of travel or flight in, or descent from or with, any aircraft under any of the following circumstances:

1. if the Insured is a pilot, officer, or member of the crew of the aircraft; or
2. if the Insured is operating, or assisting in the operation of that aircraft; or
3. if the Insured is giving or receiving any kind of training or instruction with respect to that aircraft; or
4. if the Insured is aboard that aircraft for any purpose other than that of being transported therein as a passenger; or
5. if the Insured is aboard or is descending from an aircraft while participating in parachute jumping, sky diving or similar activity.

If death so occurs that the foregoing provisions limit the Company's liability under this policy, then, notwithstanding any and all other provisions of this entire policy, the Company's liability under this policy shall be limited to the payment in a single sum of an amount equal to the sum of the premiums paid on this policy, less dividends apportioned and credited, or the life insurance reserve on the policy, whichever is greater; provided, however, that the amount so payable shall not exceed the amount which would otherwise be payable, if this exclusion rider were not in effect. Any dividends standing to the credit of the policy and the reserve on any dividend additions shall be added to the amount payable; any indebtedness due the Company on the policy shall be deducted.

If this policy contains a provision for an additional benefit in event of death by external, violent, and accidental means, the conditions and exceptions set forth in that provision are hereby supplemented, (without being waived or lessened in any way) provided that in no event shall that additional benefit be payable if the death of the Insured occurs under such circumstances that the liability of the Company is limited by the terms of this Aviation Risk Exclusion Rider.

The provisions of this rider shall also apply to any reduced paid-up insurance or extended insurance put in force in accordance with any Non-forfeiture Provisions contained in this policy, and shall be included in any policy to which this policy may be changed or converted.

The defense or denial of liability by the Company with respect to any claim under this policy on the grounds that death occurred as a result of any of the causes and under the circumstances stated in this rider shall not be construed to be a contest of this policy.

Attached to and made a part of

Policy No.

Insuring

Saint Paul, Minnesota,

Countersigned by

Secretary Registrar President

Firm/Rep:

MINNESOTA LIFE

MILITARY/AVIATION STATEMENT

Minnesota Life Insurance Company • Individual Underwriting • 400 Robert Street North • St. Paul, Minnesota 55101-2098

PROPOSED INSURED'S NAME (Please Print)

MILITARY STATEMENT. Complete the appropriate section on: (1) M.D.'s and Medical Students under age 35 (2) ROTC, National Guard Reserve and Military Personnel.

A. CIVILIAN APPLICANTS

1a. Are you in the Reserve or National Guard? ☐ Yes ☐ No
b. ☐ Inactive ☐ Active (If Active, Complete Section B.)

2a. Are you in the ROTC? (If yes, Complete Section B.) ☐ Yes ☐ No
b. ☐ Basic ☐ Advanced

3. If physician or dentist
a. Is your military service completed? ☐ Yes ☐ No
b. Will you be a flight surgeon or a flight medical officer? ☐ Yes ☐ No
c. Are you in the Berry Plan or any other Military Education Plan? ☐ Yes ☐ No
d. Branch of Service? _____

4. Do you expect to be called for active duty? ☐ Yes ☐ No

5. If yes, give date _____ and Complete Section B.

B. MILITARY PERSONNEL

1. Branch of Service _____ Pay Grade _____

2a. All MOS and occupational classifications _____
b. Are you drawing hazardous duty pay? ☐ Yes ☐ No
(If yes, explain below)

3a. Are you attending or a graduate of a military academy? ☐ Yes ☐ No
b. School _____ Graduation Date _____

4. Are you on flight duty now or will you fly as a pilot, crew member or flight surgeon in the future? ☐ Yes ☐ No
(If yes, complete Aviation Statement.)

5a. Are you on orders or have you been alerted for overseas duty? _____ ☐ Yes ☐ No
b. If yes, give details consistent with Security Regulations
Date of Departure _____ New Station _____
Duty Assignment, etc. _____

AVIATION STATEMENT. Complete on all Military or Civilian Pilots and Crewmembers or other Flight Personnel.

1. Type of License or certificate _____
a. Date issued _____
b. Date of last flight physical _____

2. Type of Aircraft (Make and Model Number) _____

3. Do you rent, lease or own the aircraft? _____

4. Total hours flown as pilot _____ Crew _____

5. Date of last flight as pilot _____ Crew _____

6. Has your license or certificate ever been revoked or suspended? (If yes, give details below.) ☐ Yes ☐ No

7. As a pilot, have you ever had an aviation accident or violation? (If yes, give details below.) ☐ Yes ☐ No

8. If a private pilot, are you Instrument Flight Rated (IFR)? ☐ Yes ☐ No

9. Do you ever fly outside the continental U.S. or Canada? (If yes, give details below.) ☐ Yes ☐ No

10. Do you want full aviation coverage if eligible? (An extra premium may be necessary.) ☐ Yes ☐ No

TYPE OF FLYING			Next 12 Mos.	Last 12 Mos.	1-2 Yrs. Ago	2-3 Yrs. Ago
1a. Scheduled Airlines	☐ Domestic ☐ International (Explain below)	Pilot ☐ Crew ☐				
b. Company owned executive aircraft used for transportation of employees.		Pilot ☐ Crew ☐				
c. Non-scheduled airlines, charter, photography, surveying, sight-seeing, aerial application, crop dusting, testing, glider. (Explain below and advise of any modifications to the aircraft for this purpose)		Pilot ☐ Crew ☐				
d. Flight Instruction		Pilot ☐ Crew ☐				
e. Private and pleasure flying		Pilot ☐ Crew ☐				
f. Military Aviation	Flight Surgeon ☐	Pilot ☐ Crew ☐				
g. Helicopter		Pilot ☐ Crew ☐				
h. Any other Flying. (Explain below)	Observer ☐ Passenger ☐ Paratrooper ☐	Pilot ☐ Crew ☐				

2. ALWAYS INCLUDE TOTALS

REMARKS

I hereby declare that all statements and answers to the foregoing questions are, to the best of my knowledge and belief, complete and true and I agree that they shall form a part of my application for insurance made to Minnesota Life Insurance Company, of St. Paul, Minnesota, and of any policy issued thereunder.

WITNESS	GA/SA/CODE	APPLICANT	DATE
		X	

Individual Life Insurance Application
Family Term Agreement - Child/Additional Insured Agreement/Children's Term Agreement

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Are you applying for:

☐ Family Term Agreement - Child?
☐ Children's Term Agreement?
☐ Additional Insured Agreement? (Only available on existing Adjustable 3-89 contracts)

Children age 17 and younger may be added to the Family Term Agreement - Child or Children's Term Agreement. Children as defined in the policy are covered from age 14 days to 25 years.

Is this application to be a part of:

☐ Pending application?
☐ Existing policy?

If part of an existing policy:

☐ Increase premium to reflect the cost of the added agreements.
☐ Do not increase premium:
  ☐ Reduce base plan of insurance.
  ☐ Decrease face amount of base insured's coverage to $

BASE INSURED	FOR ADDITION TO POLICY NUMBER (IF APPLICABLE)	SUPPLEMENT TO APPLICATION DATED	EFFECTIVE DATE

Print First and Last Name of Spouse/Legal Partner and Children.		Amount	Date of Birth	Height Ft. In.	Weight	Place of Birth (State or Country)	Social Security Number
	Spouse/ Legal Partner	**$**		**Complete Non-Med (Attached)**			
	M ☐ **F** ☐	**$**					
	☐ ☐	**Same as above child**					
	☐ ☐	**Same as above child**					

(IF SPACE IS INADEQUATE, ATTACH A LIST AND HAVE IT SIGNED AND DATED)

I. QUESTIONS APPLYING TO CHILDREN (Give details to Yes answers in Remarks below.)

	Yes	No
1. Has any child listed ever had any disease or abnormality of:		
a. Heart or blood vessels, including heart murmur, or heart defect?	☐	☐
b. Lungs, including asthma, chronic cough, pneumonia, frequent bronchitis or cystic fibrosis?	☐	☐
c. Stomach, liver, intestines or rectum, including hepatitis?	☐	☐
d. Kidneys, bladder or urinary tract, including frequent bladder infections or abnormal urine findings?	☐	☐
e. Brain or nervous system, including head injuries, seizures, convulsions, epilepsy, muscular dystrophy or cerebral palsy?	☐	☐
f. Bones or joints, including rheumatic fever, arthritis or fractures from injury?	☐	☐
g. Immune system?	☐	☐
h. Skin, eyes, ears or throat, including birth marks?	☐	☐
i. Cyst, tumor, or growth of any kind, diabetes, or blood disorders, including hemophilia or leukemia?	☐	☐
2. Does any child listed:		
a. Have any physical defect or deformity?	☐	☐
b. Have any emotional problems, require counseling, or special testing?	☐	☐
3. Has any child listed:		
a. Been hospitalized beyond the newborn period (more than 3 days after birth)?	☐	☐
b. Had any operations?	☐	☐
4. Within the past five years, has any child listed been examined or treated by any doctor, PhD, or counselor for any condition not named above?	☐	☐

REMARKS

Question Number	Person to whom answer applied	Date, details, and duration of all "yes" answers above.	Names and addresses of Attending Physicians

BENEFICIARY: The Class 1 beneficiary of the Insurance under this agreement shall be the base insured, if living. If a different Class 1 beneficiary designation is desired, submit a Beneficiary Change.

AGREEMENTS: I have read, or had read to me the statements and answers recorded on my application. They are given to obtain this insurance and are, to the best of my knowledge and belief, true and complete and correctly recorded. I understand that any false statement or misrepresentation on this application may result in loss of coverage under the Agreement issued subject to the incontestability provision. I agree that they will become part of this application and any Agreement issued on it.

If this Agreement is a part of an application for a new policy, the insurance will not take effect unless and until the policy and the Agreement have been issued and delivered and the full first premium paid while the health of all Proposed Insured(s) remains as stated in the application. If the Agreement is to be added to an existing policy, it will become effective when the application for this Agreement is approved by the Company.

Date signed	Signature of insured	Signature of spouse/legal partner
	X	**X**

Licensed representative signature

X

II. AUTHORIZATION TO OBTAIN INFORMATION

COMPLETE FOR ALL APPLICATIONS

Print name of base insured

Print name of spouse/legal partner (if applicable)

AUTHORIZATION

I authorize any physician, medical practitioner, hospital, clinic or other health care provider, insurance or reinsuring company, consumer reporting agency, the Medical Information Bureau, Inc. (MIB), or employer which has any records or knowledge of my physical or mental health, and/or the physical or mental health of each minor child listed as the Proposed Insured, to give all such information and any other non-medical information relating to such persons to Minnesota Life Insurance Company or its reinsurers. This shall include ALL INFORMATION as to any medical history, consultations, diagnoses, prognoses, prescriptions or treatments and tests, including information regarding alcohol or drug abuse and AIDS or AIDS-related conditions. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by Minnesota Life to collect and transmit such information.

I understand this information is to be used for the purpose of determining eligibility for insurance and may be used for determining eligibility for benefits. I understand this information may be made available to Underwriting, Claims, support staff, licensed representatives, and firms of Minnesota Life.

I authorize Minnesota Life Insurance Company or its reinsurers to release any such information to reinsuring companies, the MIB, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

I agree this authorization shall be valid for twenty-four months from the date it is signed. I may revoke this authorization at any time by sending a written request addressed to the Individual Underwriting Department, Minnesota Life Insurance Company, 400 Robert Street North, St. Paul, MN 55101-2098.

I understand that I, or my legal representative, have the right to request and receive a copy of this authorization and that a photocopy of this authorization shall be as valid as the original.

I acknowledge that I have been given Minnesota Life's Your Privacy is Important to Us notice.

Date signed	Signature of insured	Signature of spouse/legal partner
	X	**X**

Name of minor children

III. REPRESENTATIVE'S CONFIDENTIAL REPORT - NOT PART OF THE APPLICATION

NOTE TO AGENT: If adding spouse/legal partner, use age and amount guidelines to determine requirements as outlined in the Underwriting Guideline card. Additionally, Application Parts II and III need to be completed when adding spouse/legal partner.

	Yes	No
1. Did you see each individual proposed for insurance?	☐	☐
2. Are you related to any of the proposed insureds?	☐	☐

3. If required, have you ordered?

☐ Exam ☐ EKG

☐ Blood Profile/ HOS ☐ Other _____

_____

	Yes	No
4. Was this application taken in person?	☐	☐
5. Do you know of any facts or conditions not already disclosed which may have a bearing on the underwriting of these risks?	☐	☐
6. Do you fully recommend each individual proposed for insurance and on whom an examination is not required, for insurance without a medical examination?	☐	☐

7. PERSONAL HISTORY INTERVIEW ON SPOUSE/LEGAL PARTNER: (IF APPLICABLE)

Home Phone: _____

Work Phone: _____

REMINDER: Fill out a non-medical on the base insured if adding the Family Term Agreement - Child, Children's Term Agreement, or the Additional Insured Agreement to an existing policy. Submit Beneficiary Change form (F17092-2A) only if a class 1 beneficiary other than the base insured is desired for this Agreement.

Individual Life Insurance
Certificate of Good Health

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Policy number	Applicant	Date of examination (or application)

THIS IS TO CERTIFY that, to the best of my knowledge and belief, since the above date, no person to be insured under this policy

(1) has experienced any change as to health, occupation, or other conditions of insurability; or

(2) has suffered or sustained any disabling accident or injury or lost any time from occupation or employment because of accident or sickness; or

(3) has consulted or been treated by any doctor on account of sickness or injury; or

(4) has been refused insurance by any company.

If there are any exceptions to any of the above statements, give details here:

EXCEPTIONS:

The foregoing are representations and not warranties.

Witness - representative	Signature of insured	Date
X	X	

Firm/Rep:

OP-ID:

Individual Life Insurance
Sports and Avocations Statement

Minnesota Life Insurance Company - A Securian Company
Individual Policy Services • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Proposed insured's name (please print) | Proposed insured's date of birth

SECTION 1 - SKIN DIVING (Please Complete Section III Also)

1. What type of skin diving equipment do you use?
   ☐ Snorkel ☐ Scuba ☐ Other (Explain)*
2. (a) How deep do you usually dive? _____
   (b) Do you ever go deeper? _____
   If "yes", how deep?_____ How Frequently? _____
   (c) Do you use experimental equipment or engage in diving for depth record? _____
   (d) Do you contemplate any such activity in the future?_____
3. Where is diving done?
   ☐ Great Lakes ☐ Ocean ☐ Inland Waters
   ☐ Other (Give general location. If more than one, state approximate percentage for each).*
4. How many years have you been diving? _____
5. How long do you usually stay down?_____
6. Do you dive alone? ☐ Yes ☐ No
7. Have you ever had the "bends" or "air embolism" as a result of decompression? ☐ Yes ☐ No
8. Have you had any special training? ☐ Yes ☐ No

   _____
   (State where, type and for how long)
9. (a) Indicate type of diving you do
   ☐ Pleasure ☐ Underwater Salvage
   ☐ Securing Coral ☐ Other (Explain)*

   (b) If diving only for pleasure now, do you intend to do any other type of diving in the future? ☐ Yes ☐ No

   If yes, specify _____

SECTION II - OTHER AVOCATIONS SUCH AS SKY DIVING, MOUNTAIN CLIMBING, HORSE RACING, RODEO, POLO, ETC. (Please complete Section III Also)

1. What is your avocation?
2. Have you had any special training? ☐ Yes ☐ No

   _____
   (State where, type and for how long)
3. Are you classified as a teacher or instructor in your avocation? ☐ Yes ☐ No
4. Are you considered a professional or do you ever receive cash prizes in any of these events? ☐ Yes ☐ No
5. If Sky Diving:
   (a) Have you ever participated in unusual activities such as baton exchange or use of experimental equipment? ☐ Yes ☐ No
   (b) Do you contemplate any such activity in the future? ☐ Yes ☐ No
   (c) Do you use reserve chute? ☐ Yes ☐ No
   (d) Minimum height chute opened. _____

SECTION III - EXPERIENCE

SPORT	CURRENT PARTICIPATION	LAST YEAR	1-2 YRS. AGO	NEXT YEAR	FUTURE	DATE LAST PARTICIPATED	NAME OF PROFESSIONAL ORGANIZATION

*Remarks - Use for details both Section I and II

QUESTION NO.	

Date	Signature of agent	GA/SA code	Signature of proposed insured
	X		X

SPORTS AND AVOCATIONS STATEMENT - Page 2

SECTION IV - RACING

1. Indicate:

   A. Status ☐ Amateur ☐ Professional

   B. Type ☐ Modified

   C. Vehicle:

   ☐ Big Car ☐ Sports Car ☐ Funny Car ☐ Motorcycle ☐ Boat
   ☐ Stock Car ☐ Midget ☐ Dragster ☐ Snowmobile ☐ Hydroplane
   ☐ Other (explain) _____

   D. Type of Racing:

   ☐ Speedway ☐ Scramble ☐ Time Trials ☐ Cross Country ☐ Demolition Derby
   ☐ Stock Car ☐ Rally ☐ Drag ☐ Hill Climb ☐ Sand
   ☐ Other (explain) _____

2. Give experience below. If none, so indicate.

TYPE OF RACES	NAMES OF RACES	LAST 12 MONTHS RACES	LAST 12 MONTHS MILES	1-2 YEARS AGO RACES	1-2 YEARS AGO MILES	PRIOR TO 2 YRS. AGO RACES	PRIOR TO 2 YRS. AGO MILES	CONTEMP. NEXT YR. RACES	CONTEMP. NEXT YR. MILES

3. Do you own a competition vehicle? ☐ Yes ☐ No Kind - Make & Model _____
   Other Vehicle - Kind _____ Horse Power _____

4. Do you drive any competition vehicle? _____ Kind _____
   Make and Model _____ Horse Power _____

5. How long have you participated in racing? _____

6. Date of your last race _____ Where? _____

7. What is your top speed? _____

8. Do you participate in other than sanctioned events? ..... ☐ Yes ☐ No

9. Have you had any accidents? ..... ☐ Yes ☐ No

10. (a) Have you ever done any stunt driving? ..... ☐ Yes ☐ No
    (b) Do you intend to do stunt driving in the future? ..... ☐ Yes ☐ No

11. (a) Have you ever raced professionally or for cash prizes? ..... ☐ Yes ☐ No
    (b) Do you intend to race professionally or for cash prizes in the future? .... ☐ Yes ☐ No
    (If "yes" give details)*

12. Do you race only in your hometown or do you compete in various localities?*

*Remarks - Use for Details

QUESTION NO.	

Date _____

Witness _____

_____
Signature of Proposed Insured

Individual Life Insurance
Ownership Endorsement

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
Life Policy Administration • 400 Robert Street North • St. Paul, Minnesota 55101-2098

Policy number	Insured	Firm/rep code

This endorsement, when acknowledged by the Company at its Home Office, is a part of the policy and subject to all policy terms and conditions.

Owner and relationship to insured

Notwithstanding any contrary policy provision, every benefit, privilege, or right granted the Insured by the terms of this policy shall be payable to, or maybe exercised by, the Owner named and described above and not by the Insured. No notice to, or consent of, the Insured shall be required for any transaction between the Company and the Owner with respect to this policy, including exercise of the right to change the beneficiary and of the rights and title evidenced by this endorsement.

Date

Robert L Senkler
President

Dennis E. Prohofsky
Secretary

Firm/Rep:

OP-ID:

ATTACH THIS ENDORSEMENT TO YOUR POLICY

Chemical Use Questionnaire

Minnesota Life Insurance Company - A Securian Company
Life New Business ● 400 Robert Street North ● St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

To be completed by the Proposed Insured.

Name	Date of birth	Firm/rep

Are you currently using, or in the past 10 years, have you ever used the following chemicals: (Please provide details below.)

	Yes	No
A. Alcohol (such as beer, wine, liquor)?	☐	☐
B. Narcotics (such as heroin, opium, demerol, or their derivatives)?	☐	☐
C. Hallucinogens (such as LSD, PCP, DMT, STP, or their derivatives)?	☐	☐
D. Methamphetamines or stimulants (such as cocaine, crack, ice, crank, amphetamines, antidepressants)?	☐	☐
E. Depressants (such as bromides, barbiturates, or their derivatives)?	☐	☐
F. Tranquilizers (such as valium, librium, haldol, or their derivatives)?	☐	☐
G. Marijuana (such as hash, pot, grass, tea)?	☐	☐
H. Other	☐	☐

Type	Usual Quantity	How Often	Dates	
			From	To

	Yes	No
Have you ever in the past 10 years consulted, been advised by or been treated by any physician, counselor, therapist, or facility for chemical usage?	☐	☐
If yes, please indicate the date(s) of consultation(s) and the name(s) and addresses of attending physicians or facilities. _____		
As a result of chemical usage, have you ever in the past 10 years attended a support organization? (Alcoholics Anonymous, Impaired Physicians Program, halfway houses, drug treatment, or after care programs)	☐	☐

If yes, what and when? _____

How long were you or have you been an active participant? _____

Are you presently an active participant? _____

Please make any comments you would like concerning this matter in the space provided below.

_____

_____

_____

AGREEMENTS: I have read the statements and answers recorded on this questionnaire. They are given to obtain insurance and are, to the best of my knowledge and belief, true and complete and correctly recorded. I agree that this questionnaire will be attached to and made part of the application and any coverage issued on it.

Signature of proposed insured	Date
X	

Individual Life Insurance
Supplement to Application Part 1
Variable Adjustable Life Survivor

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
LIfe New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

To be completed ONLY IF APPLYING FOR ADDITIONAL BENEFITS AND AGREEMENTS.

Supplement to the Application Part 1 dated: _____

First Insured's Name (Last, First, Middle Initial) Date of Birth (Mo., Day, Yr.)

Second Insured's Name (Last, First, Middle Initial) Date of Birth (Mo., Day, Yr.)

ADDITIONAL BENEFITS AND AGREEMENTS

☐ Estate Preservation Agreement

Designated Life. . . . . _____

Face Amount (cannot exceed 122% of base amount). . . . . .$_____

☐ Waiver of Premium Agreement (available on either insured or both). . . . . ☐ First Insured ☐ Second Insured

Correspondence should be sent to _____ (may be different than premium payor.)
(Name of joint owner to receive correspondence.)

Additional information may be provided below and in the Additional Remarks section of the Application Part 1 (page 2) or in a cover memo.

ADDITIONAL INFORMATION

Individual Life Insurance
Home Office Corrections or Additions

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Acceptance of the policy shall ratify changes entered here by Minnesota Life. Not to be used in IL, NJ, or OR for change in age, amount, classification, plan or benefits unless agreed to in writing.

Date	Assistant Secretary signature X

Individual Life Insurance Application Part 1

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

A. Proposed Insured Information

Proposed insured name (last, first, middle)

Social Security number	Date of birth (month, day, year)	Gender ☑ Male ☐ Female

Driver's license number	Issue state	Expiration date

Primary telephone number	Secondary telephone number

Birthplace (state or, if outside the US, country)	E-mail address

Street address (no P.O. Box)

City	State	Zip code

Occupation	Years in occupation	Income	Net worth

B. Product

Product applied for	Base face amount $

Total annual planned premium (excluding NRP)	Plan of insurance (if applicable)

Death benefit qualification test (if applicable, defaults to GPT if none selected)

☐ Guideline Premium Test (GPT) ☐ Cash Value Accumulation Test (CVAT)

Death benefit option (defaults to Cash/Level if none selected)

☐ Cash/Level ☐ Protection/Increasing ☐ Sum of Premiums

Dividend option (if applicable, defaults to Policy Improvement for AL Legend and Paid-Up Additions for Secure)

C. Additional Benefits and Agreements

Select only those agreements available on the product(s) applied for.

☐ Accelerated Benefit Agreement
(Submit ABA Outline of Coverage form)
☐ Accidental Death Benefit Agreement
☐ Additional Insurance Agreement
$_____
☐ Children's Term or Family Term Agreement
(Submit Family Term Application)
☐ Death Benefit Guarantee Agreement
☐ Early Values Agreement
☐ Estate Preservation Agreement
$_____
Face Amount (Not to exceed 122% of base amount)
☐ Face Amount Increase Agreement
☐ Guaranteed Insurability Option Agreement
$_____
☐ Guaranteed Insurability Option Agreement Waiver
$_____
☐ Long-Term Care Agreement
(Submit LTC Supplemental Application)
☐ Overloan Protection Agreement
☐ Single Premium Paid-Up Additional Insurance Agreement
☐ Surrender Value Enhancement
☐ Term Insurance Agreement
$_____
☐ Waiver of Charges Agreement
☐ Waiver of Premium Agreement
☐ Other
_____
☐ Other
_____

THE FOLLOWING BENEFITS AND AGREEMENTS *WILL BE ADDED* IF AVAILABLE FOR YOUR POLICY, UNLESS YOU CHOOSE TO OMIT THEM:

☐ Omit Automatic Premium Loan Provision
☐ Omit Cost of Living Agreement
☐ Omit Inflation Agreement

D. Special Dating

☐ Date to save age
☐ Specific date (month/day/year): _____ (cannot select 29th, 30th, or 31st of the month)

Are there any other Minnesota Life applications associated with this application? ☐ Yes ☐ No
If yes, please provide Proposed Insured(s) full name(s) and whether the policies should have the same issue date.

E. Life Insurance In Force and Replacement

Submit appropriate replacement forms (not needed if replacing group coverage).

Does the Proposed Insured have any life insurance or annuity in force or pending, including life insurance sold or assigned, or is in the process of being sold or assigned, to a life settlement, viatical or secondary market provider? If yes, provide details in the chart below. ☐ Yes ☐ No

Has there been, or will there be, replacement of any existing life insurance or annuity, as a result of this application? (Replacement includes, but is not limited to, a lapse, surrender, 1035 Exchange, loan, withdrawal, or other change to any existing life insurance or annuity.) If yes, provide details in the chart below. ☐ Yes ☐ No

Life Insurance In Force

Full Company Name	Amount	Year Issued	Type	Will it be Replaced?
			☐ Individual or ☐ Group ☐ Personal or ☐ Business	☐ Yes ☐ No
			☐ Individual or ☐ Group ☐ Personal or ☐ Business	☐ Yes ☐ No
			☐ Individual or ☐ Group ☐ Personal or ☐ Business	☐ Yes ☐ No

F. Beneficiary Information

If the beneficiary is a trust, give complete trust name and date trust established.

	Beneficiary First and Last Name	Relationship to Proposed Insured	SSN/TIN (If known)
Primary			
Contingent			

G. Owner Information

Submit the appropriate trust, corporate, or non-corporate form(s).

Only complete this section if the Owner is different than the Insured.

Owner name (last, first, middle)

☐ Individual

☐ Trust (submit Certification of Trustee Authority form)

☐ Corporate (submit Corporate/Non-Profit Resolution and Employer Notification Regarding the Potential Taxation of Death Benefit forms)

☐ Partnership (submit Partnership/LLC Resolution and Employer Notification Regarding the Potential Taxation of Death Benefit forms)

☐ Other_____

Social Security or tax ID number	Date of birth or trust date
Street address (no P.O. box)	
City / State / Zip code	
Relationship to proposed insured / Telephone number	
E-mail address	

H. Premium and Billing Information

Premium Notice Should Be Sent To:

☐ Proposed Insured Address in Section A ☐ Owner Address in Section G
☐ Owner's Business/Employer Address (Indicate below) ☐ Other (Indicate below)

Name			
Address	City	State	Zip code

Payment Method:

☐ Annual ☐ Quarterly
☐ Semi-Annual ☐ Monthly Electronic Funds Transfer (EFT) Plan Number_____
(If new plan, submit EFT/APP Authorization)
☐ Payroll Deduction Plan (PRD) Plan Number_____

☐ List Bill Plan Number _____ (if new plan, submit List Bill Setup form)

Third Party Notification (optional):
If you wish, you may give us the name and address of a person whom you designate to also receive notice of an overdue premium or pending lapse. (Indicate below)

Name			
Address	City	State	Zip code

I. Additional Premium

1035 Exchange ☐ Yes ☐ No
(If yes, submit 1035 Exchange Agreement form)

Non-Repeating Premium (NRP)
Regular NRP $_____

Billable Non-Repeating Premium (Billable NRP)
(If base premium is paid through a list bill, the NRP must also be billed through the same list bill.)

Total Annual Billable NRP $_____
(Minimum annual $600 NRP required. Minimum annual $2,400 base premium required.)

Include Billable NRP at issue, with first premium payment? ☐ Yes ☐ No

Payment Method
☐ Annual ☐ Monthly Electronic Funds Transfer (EFT) Plan Number_____
(If new plan, submit EFT/APP Authorization)
☐ Semi-Annual ☐ Payroll Deduction Plan (PRD) Plan Number_____
☐ Quarterly

Universal Life Additional Premium (excluding 1035)
$_____

J. Money Submitted with Application

Make all checks payable to Minnesota Life.

Has the Owner paid money with this application to the representative? ☐ Yes ☐ No
If yes, amount: $_____

Was a Life and Temporary Insurance Agreement given? ☐ Yes ☐ No

K. Special Mailing Address

If mail (other than the premium notice) should be sent somewhere other than the Owner's Home Address, please indicate here.
☐ Owner's Business Address
☐ Other - Indicate Name and Address

Name (last, first, middle)		
Address		
City	State	Zip code

L. Request for Illustration

Complete for non-variable products, excluding Advantage Elite 5-30 and ART SD.

Choose one of the following:

☐ An illustration matching the policy applied for was presented to the Owner/Applicant and a signed copy is included with this application. The Owner/Applicant has received a copy.

☐ An illustration was presented or provided to the Owner/Applicant, but is different from the policy applied for. An illustration conforming to the policy as issued will be provided to the Owner/Applicant no later than at the time of policy delivery.

☐ No illustration conforming to the policy as applied for was shown or provided to the Owner/Applicant prior to or at the time of taking this application. An illustration conforming to the policy as issued will be provided to the Owner/Applicant no later than at the time of policy delivery.

M. Proposed Insured Underwriting Information

1. Is the proposed insured a US citizen? ☐ Yes ☐ No

   If no, citizen of _____

   Indicate visa type _____

2. Does the proposed insured plan to travel or reside outside the US in the next two years? ☐ Yes ☐ No
   If yes, provide the city(s) and country(s), dates, length of stay, and purpose of travel:

   _____

   _____

3. Has the proposed insured within the last five years, or does the proposed insured plan to engage in piloting a plane? If yes, complete the Military and Aviation Statement. ☐ Yes ☐ No

4. Has the proposed insured within the last five years, or does the proposed insured plan to engage in sky diving, motor vehicle or boat racing, mountain/rock climbing, hang gliding, or underwater diving? If yes, complete Sports and Avocation Statement. ☐ Yes ☐ No

5. Is the proposed insured in the Armed Forces, National Guard, or Reserves? ☐ Yes ☐ No
   If yes, complete Military and Aviation Statement.

6. Has the proposed insured applied for insurance within the last six months? ☐ Yes ☐ No
   If yes, provide details below.

   _____

   _____

7. Has the proposed insured applied for life insurance in the past five years that was declined or rated? If yes, provide details below. ☐ Yes ☐ No

   _____

   _____

8. Has the proposed insured, within the past ten years, been convicted of a driving while intoxicated violation, had a driver's license restricted or revoked, or been convicted of a moving violation? If yes, provide dates and details below. ☐ Yes ☐ No

   _____

   _____

9. Except for traffic violations, has the proposed insured ever been convicted of a misdemeanor or felony? If yes, provide dates and details below. ☐ Yes ☐ No

   _____

   _____

10. Will the Proposed Owner and/or beneficiary, and/or any entity on the Proposed Owner's behalf, receive any compensation, whether via the form of cash, property, an agreement to pay money in the future, a percentage of the death benefit, or otherwise if this policy is issued? ☐ Yes ☐ No

11. Has the Proposed Owner been involved in any discussion about the possible sale or assignment of this policy or a beneficial interest in a trust, LLC, or other entity created on the owner's behalf? If yes, provide details and a copy of the applicable entity's controlling documents. ☐ Yes ☐ No

    _____

    _____

	12. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? If yes, submit the Premium Financing Advisor Attestation and Premium Financing Client Disclosure forms. ☐ Yes ☐ No 13. Have you had a life expectancy report or evaluation done by an outside entity or company? If yes, please explain why the expectancy report was obtained. ☐ Yes ☐ No _____ _____
N. Additional Remarks	
O. Home Office Endorsements	**Home Office Corrections or Additions** Acceptance of the policy shall ratify changes entered here by Minnesota Life. Not to be used in IL, NJ, or, OR for change in age, amount, classification, plan or benefits unless agreed to in writing.

Individual Life Insurance Policy Change Application Part 3 (Underwriting) Agreements and Authorizations

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
Individual Life Policy Administration • 400 Robert Street North • St. Paul, Minnesota 55101-2098

Insured name (last, first, middle)

AGREEMENTS: I have read, or had read to me the statements and answers recorded on my application. They are given to obtain this insurance and are, to the best of my knowledge and belief, true and complete and correctly recorded. I agree that they will become part of this application and any coverage issued on it. I understand that the policy will be contestable, as to representations in this application, from the date of reinstatement or reissue, for the time period stated in the incontestable provision of the policy. The insurance applied for will not take effect unless and until the policy is reissued and delivered and the full first premium is paid while the health of the Insured remains as stated in this Policy Change Application, as provided in the Life Receipt and Temporary Insurance Agreement.

VARIABLE LIFE: I understand that the amount or the duration of the death benefit (or both) of the policy applied for may increase or decrease depending on the investment results of the sub-accounts of the separate account. I understand that the actual cash value of the policy applied for is not guaranteed and increases and decreases depending on the investment results. There is no minimum actual cash value for the policy values invested in these sub-accounts.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, clinic or other health care provider, insurance or reinsuring company, consumer reporting agency, the Medical Information Bureau, Inc. (MIB), or employer which has any records or knowledge of my physical or mental health, and/or the physical or mental health of each minor child listed as the Proposed Insured, to give all such information and any other non-medical information relating to such persons to Minnesota Life Insurance Company or its reinsurers. This shall include ALL INFORMATION as to any medical history, consultations, diagnoses, prognoses, prescriptions or treatments and tests, including information regarding alcohol or drug abuse and AIDS or AIDS-related conditions. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by Minnesota Life Insurance Company to collect and transmit such information.

I understand this information is to be used for the purpose of determining eligibility for insurance and may be used for determining eligibility for benefits. I understand this information may be made available to Underwriting, Claims, support staff, licensed representatives, and firms of Minnesota Life Insurance Company. I authorize Minnesota Life Insurance Company or its reinsurers to release any such information to reinsuring companies, the MIB, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

I agree this authorization shall be valid for twenty-four months from the date it is signed. I may revoke this authorization at any time by sending a written request addressed to the Individual Underwriting Department, Minnesota Life Insurance Company, 400 Robert Street North, St. Paul, MN 55101-2098.

I understand that I, or my legal representative, have the right to request and receive a copy of this authorization and that a photocopy of this authorization shall be as valid as the original. I understand that no sales representative has the company's authorization, to accept risk, pass on insurability, or make, or void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

I acknowledge that I have been given the Your Privacy Is Important To Us notice.

FRAUD WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be guilty of a criminal offense and subject to penalties under state law.

☐ Change Service Representative (Print name/code only if policy is being reassigned)	Representative name	Firm/rep code

Insured signature **X**	Date	City	State
Owner signature (if other than Insured) (give title if signed on behalf of a business) **X**	Date	City	State
Assignee signature (give title if signed on behalf of a business) **X**	Date	City	State
Irrevocable beneficiary signature (give title if signed on behalf of a business) **X**	Date	City	State
Parent/conservator/guardian signature (juvenile applications) **X**	Date	City	State

I believe that the information provided by this applicant is true and accurate. I certify I have accurately recorded all information given by the Insured(s).

Licensed representative signature **X**	Firm/rep code	Date

Individual Life Insurance Application Part 3
Agreements and Authorizations

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

Proposed insured name (last, first, middle)

AGREEMENTS: I have read, or had read to me the statements and answers recorded on my application. They are given to obtain this insurance and are, to the best of my knowledge and belief, true and complete and correctly recorded. I understand that any false statement or misrepresentation on this application may result in loss of coverage under this policy subject to the incontestability provision. I agree that they will become part of this application and any policy issued on it. The insurance applied for will not take effect unless the policy is issued and delivered and the full first premium is paid while the health of the Proposed Insured remains as stated in this application. **If such conditions are met, the insurance will take effect as of the earlier of the Policy Date specified in the policy or the date the policy is delivered to me; the only exception to this is provided in the Life Receipt and Temporary Insurance Agreement, issued if the premium is paid in advance.**

VARIABLE LIFE: I understand that the amount or the duration of the death benefit (or both) of the policy applied for may increase or decrease depending on the investment results of the sub-accounts of the separate account. I understand that the actual cash value of the policy applied for is not guaranteed and increases and decreases depending on the investment results. There is no minimum actual cash value for the policy values invested in these sub-accounts.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, clinic or other health care provider, insurance or reinsuring company, consumer reporting agency, the Medical Information Bureau, Inc. (MIB), or employer which has any records or knowledge of my physical or mental health, and/or the physical or mental health of each minor child listed as the Proposed Insured, to give all such information and any other non-medical information relating to such persons to Minnesota Life Insurance Company or its reinsurers. This shall include ALL INFORMATION as to any medical history, consultations, diagnoses, prognoses, prescriptions or treatments and tests, including information regarding alcohol or drug abuse and AIDS or AIDS-related conditions. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by Minnesota Life Insurance Company to collect and transmit such information.

I understand this information is to be used for the purpose of determining eligibility for insurance and may be used for determining eligibility for benefits. I understand this information may be made available to Underwriting, Claims, support staff, licensed representatives, and firms of Minnesota Life Insurance Company. I authorize Minnesota Life Insurance Company or its reinsurers to release any such information to reinsuring companies, the MIB, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

I agree this authorization shall be valid for twenty-four months from the date it is signed. I may revoke this authorization at any time by sending a written request addressed to the Individual Underwriting Department, Minnesota Life Insurance Company, 400 Robert Street North, St. Paul, MN 55101-2098.

I understand that I, or my legal representative, have the right to request and receive a copy of this authorization and that a photocopy of this authorization shall be as valid as the original. I understand that no sales representative has the company's authorization, to accept risk, pass on insurability or make, or void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

I acknowledge that I have been given the Your Privacy Is Important To Us notice.

FRAUD WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be guilty of a criminal offense and subject to penalties under state law.

Proposed insured signature **X**	Date	City	State
Owner signature (if other than proposed insured) (give title if signed on behalf of a business) **X**	Date	City	State
Parent/conservator/guardian signature (juvenile applications) **X**	Date	City	State

I believe that the information provided by this applicant is true and accurate. I certify I have accurately recorded all information given by the Proposed Insured(s).

Licensed representative signature **X**	Date

Individual Life Insurance
Policy Change Application
No Underwriting Required

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
Individual Life Policy Administration • 400 Robert Street North • St. Paul, Minnesota 55101-2098

A. Request Information

Make all checks payable to Minnesota Life.

Policy number(s)

Insured name (last, first, middle)

Money submitted with application

$_____

☐ Receipt Given

Effective date of change

☐ Current Date ☐ Date Of Next EFT/APP Draw

☐ Other (Indicate mm/yy and reason) _____

B. Owner Information

Owner name (last, first, middle)

Telephone number ☐ Primary ☐ Secondary

E-mail address

C. Address Adjustments

☐ Change Owner Home Address

☐ Add/Change Mailing Address

☐ Premium Notices Only ☐ All Correspondence Other Than Premium Notice ☐ All Mail

Name (last, first, middle)

Address

City | State | Zip

D. Face Amount Adjustments

☐ Change Face Amount: $_____
(Unless otherwise indicated, for Adjustable products, we will maintain the premium and adjust the plan.)

☐ Cost Of Living Alternate Exercise ☐ AIO/AIOW/FAIA/GIO Exercise

☐ Inflation Rider Exercise ☐ Alternate Option Date:_____ (Attach Proof)

E. Premium and Billing Information

Premium Adjustment

☐ Change Total Annual Planned Premium Amount: $_____
(Unless otherwise indicated, for Adjustable products, we will maintain the face amount and adjust the plan.)

Payment Method

☐ Annual ☐ Monthly Electronic Funds Transfer (EFT/APP) Plan Number:_____
(If new plan, submit EFT/APP Authorization)

☐ Semi-Annual ☐ List Bill Plan Number:_____
(If new plan, submit List Bill form)

☐ Quarterly ☐ Payroll Deduction Plan (PRD) Plan Number:_____

Non-Repeating Premium (NRP)

Regular NRP $_____ ☐ Increase Face By NRP Amount ☐ Do Not Increase Face By NRP Amount

Billable Non-Repeating Premium (Billable NRP)

(If base premium is paid through a list bill, the NRP must also be billed through the same list bill.)

Total Annual Billable NRP $_____
(Minimum annual $600 NRP required. Minimum annual $2,400 base premium required.)

Payment Method

☐ Annual ☐ Monthly Electronic Funds Transfer (EFT/APP)
Plan Number_____ (If new plan, submit EFT/APP Authorization)

☐ Semi-Annual ☐ Payroll Deduction Plan (PRD) Plan Number_____

☐ Quarterly

1035 Exchange ☐ Yes ☐ No
(If yes, submit 1035 Exchange Agreement form)

F. Plan Adjustments

☐ Change Plan Of Insurance: ☐ Life At Age:_____ ☐ Protection To Age:_____
(Unless otherwise indicated, for Adjustable products, we will maintain the face amount and adjust the premium.)

G. Partial Surrenders

☐ Partial Surrender to Cash: $_____ or ☐ Max Amount

☐ Partial Surrender to Eliminate Policy Loan (Dividend additions and accumulations will be surrendered first)

The death benefit amount will be reduced.

If a correct Social Security or Tax ID number is not provided, the IRS requires Minnesota Life to withhold 10% of any taxable gain, irrespective of the withholding election. This applies to all partial surrenders and loan eliminations with taxable gain. Complete withholding section and enter Social Security number/tax ID number below. ☐ Yes, I elect withholding ☐ No, I do not elect withholding

Owner's Social Security number/tax ID number

H. Conversions

☐ Conversion Term Insurance At Attained Age ☐ Partial Conversion Amount: $_____
☐ Surrender balance ☐ Retain balance

Select Product:

☐ Adjustable Life Legend
☐ Adjustable Life Summit
☐ Secure Whole Life
☐ Variable Adjustable Life Horizon
☐ Variable Adjustable Life Summit
☐ Other_____

☐ Accumulator Variable Universal Life
☐ Eclipse Indexed Universal Life
☐ Eclipse Protector Indexed Universal Life

(For Eclipse, Eclipse Protector, and Accumulator, select a Death Benefit Qualification Test. If none selected the default is GPT)

☐ Guideline Premium Test (GPT)
☐ Cash Value Accumulation Test (CVAT)

Select a Death Benefit or Dividend Option in Section I.
For Variable Adjustable Life and Universal Life, the default death benefit option is Level/Cash.
For Adjustable Life Legend, the default dividend option is Policy Improvement.
For Secure Whole Life, the default dividend option is Paid-Up Additions.

☐ Convert Term Insurance Into Existing Policy

Existing Policy Number:_____

☐ Convert Term Agreement

Term Agreement:_____ Insured Name:_____

Automatic Premium Loan (APL) Provision is automatically *added* at conversion, if available for the product, unless indicated here: ☐ Omit Automatic Premium Loan Provision

I. Other Adjustments

☐ Change Death Benefit Option To:

☐ Cash/Level ☐ Protection/Increasing ☐ Sum of Premiums

The Protection death benefit option generally requires underwriting. If changing from Level Death Benefit Option the face amount will decrease.

☐ Change Dividend Option To:

_____

J. Additional Agreements

Select only those agreements available on the products applied for.

☐ **Maintain** Current Annual Premium ☐ **Change** Current Annual Premium Accordingly

	ADD	REMOVE	DECREASE AMOUNT	NEW AMOUNT
Accidental Death Benefit Agreement		☐		
Additional Insured Agreement		☐	☐	$_____
Adjustable Survivorship Life Agreement		☐	☐	$_____
Automatic Premium Loan Provision	☐	☐		
Business Continuation Agreement Designated Life_____		☐	☐	$_____
Children's Term or Family Term Children's Agreement		☐	☐	$_____
Cost of Living Agreement		☐		
Death Benefit Guarantee Agreement*	☐	☐		
Early Values Agreement*	☐			
Enhanced Guaranteed Agreement	☐	☐		
Enhanced Guaranteed Choice Agreement	☐	☐		
Estate Preservation Agreement		☐		
Face Amount Increase Agreement		☐	☐	$_____
Family Term - Spouse Agreement		☐	☐	$_____
Guaranteed Insurability Option Agreement		☐	☐	$_____
Guaranteed Insurability Option Agreement Waiver		☐		
Guaranteed Protection Waiver		☐		
Interest Accumulation Agreement		☐	☐	_____%
Inflation Agreement		☐		
Long-Term Care Agreement		☐	☐	$_____
Overloan Protection Agreement	☐	☐		
Policy Enhancement Rider (Indicate a whole number from 3 to 10%)			☐	_____%
Single Premium Paid Up Additional Insurance Agreement	☐	☐		
Surrender Value Enhancement Agreement		☐		
Term Insurance Agreement		☐		
Waiver of Charges Agreement		☐		
Waiver of Premium Agreement		☐		

Other:_____

**Can only be added when converting term insurance to a new policy.*

K. Life Insurance In Force and Replacement

Submit appropriate replacement forms (not needed if replacing group coverage).

Does the Insured have any life insurance or annuity in force or pending? ☐ Yes ☐ No

Has there been, or will there be, replacement of any existing life insurance or annuity, as a result of this application? (Replacement includes, but is not limited to, a lapse, surrender, 1035 Exchange, loan, withdrawal, or other change to any existing life insurance or annuity.) If yes, provide details on the Replacement Disclosure Statement. ☐ Yes ☐ No

L. Additional Remarks

M. Home Office Endorsements

Home Office Corrections or Additions

Acceptance of the policy shall ratify changes entered here by Minnesota Life. Not to be used in IA, IL, KS, KY, MD, MI, MN, MO, NH, NJ, OR, PA, TX, VT, WA, WI, or WV for change in age, amount, classification, plan or benefits unless agreed to in writing.

N. Agreements

AGREEMENTS: I have read, or had read to me the statements and answers recorded on my application. They are given to obtain this insurance and are, to the best of my knowledge and belief, true, complete, and correctly recorded. I agree that they will become part of this application and any policy issued on it.

VARIABLE LIFE: I understand that the amount or the duration of the death benefit (or both) of the policy applied for may increase or decrease depending on the investment results of the sub-accounts of the separate account. I understand that the actual cash value of the policy applied for is not guaranteed and increases and decreases depending on the investment results. There is no minimum actual cash value for the policy values invested in these sub-accounts.

FRAUD WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be guilty of a criminal offense and subject to penalties under state law.

☐ Change Service Representative (Print name/code only if policy is being reassigned)	Representative name	Firm/rep code

Owner signature (give title if signed on behalf of a business) **X**	Date	City	State
Assignee signature (give title if signed on behalf of a business) **X**	Date	City	State
Irrevocable beneficiary signature (give title if signed on behalf of a business) **X**	Date	City	State
Parent/conservator/guardian signature (juvenile applications) **X**	Date	City	State

I believe that the information provided by this applicant is true and accurate. I certify I have accurately recorded all information given by the Owner(s).

Licensed representative signature **X**	Firm/rep code	Date

Individual Life Insurance
Policy Change Application Part 1
Underwriting Required

[MINNESOTA LIFE]

[Minnesota Life Insurance Company - A Securian Company
Individual Life Policy Administration • 400 Robert Street North • St. Paul, Minnesota 55101-2098]

A. Request Information

Make all checks payable to Minnesota Life.

Policy number(s)

Insured name (last, first, middle)

Money submitted with application

$_____

☐ Receipt Given

Effective date of change

☐ Current Date ☐ Date Of Next EFT/APP Draw

☐ Other (Indicate mm/yy and reason)_____

B. Owner Information

Owner name (last, first, middle)

Telephone number ☐ Primary ☐ Secondary

E-mail address

C. Address Adjustments

☐ Change Owner Home Address

☐ Add/Change Mailing Address

☐ Premium Notices Only ☐ All Correspondence Other Than Premium Notice ☐ All Mail

Name (last, first, middle)

Address

City | State | Zip

D. Face Amount Adjustments

☐ Change Face Amount: $_____
(Unless otherwise indicated, for Adjustable products, we will maintain the premium and adjust the plan.)

☐ Cost Of Living Alternate Exercise ☐ AIO/AIOW/FAIA/GIO Exercise

☐ Inflation Rider Exercise ☐ Alternate Option Date:_____ (Attach Proof)

E. Premium and Billing Information

Premium Adjustment

☐ Change Total Annual Planned Premium Amount: $_____
(Unless otherwise indicated, for Adjustable products, we will maintain the face amount and adjust the plan.)

Payment Method

☐ Annual

☐ Semi-Annual

☐ Quarterly

☐ Monthly Electronic Funds Transfer (EFT/APP) Plan Number:_____
(If new plan, submit EFT/APP Authorization)

☐ List Bill Plan Number:_____
(If new plan, submit List Bill form)

☐ Payroll Deduction Plan (PRD) Plan Number:_____

Non-Repeating Premium (NRP)

Regular NRP $_____ ☐ Increase Face By NRP Amount ☐ Do Not Increase Face By NRP Amount

Billable Non-Repeating Premium (Billable NRP)
(If base premium is paid through a list bill, the NRP must also be billed through the same list bill.)

Total Annual Billable NRP $_____
(Minimum annual $600 NRP required. Minimum annual $2,400 base premium required.)

Payment Method

☐ Annual

☐ Semi-Annual

☐ Quarterly

☐ Monthly Electronic Funds Transfer (EFT/APP) Plan Number_____
(If new plan, submit EFT/APP Authorization)

☐ Payroll Deduction Plan (PRD) Plan Number_____

1035 Exchange ☐ Yes ☐ No
(If yes. submit 1035 Exchange Agreement form)

F. Plan Adjustments

☐ Change Plan Of Insurance: ☐ Life At Age:_____ ☐ Protection To Age:_____
(Unless otherwise indicated, for Adjustable products, we will maintain the face amount and adjust the premium.)

G. Partial Surrenders

☐ Partial Surrender to Cash: $_____ or ☐ Max Amount

☐ Partial Surrender to Eliminate Policy Loan (Dividend additions and accumulations will be surrendered first)

The death benefit amount will be reduced. To maintain current face amount check below (underwriting is required):

☐ Maintain Face Amount

If a correct Social Security or Tax ID number is not provided, the IRS requires Minnesota Life to withhold 10% of any taxable gain, irrespective of the withholding election. This applies to all partial surrenders and loan eliminations with taxable gain. Complete withholding section, and enter Social Security number and tax ID number below. ☐ Yes, I elect withholding ☐ No, I do not elect withholding

Owner's Social Security number/tax ID number

H. Conversions

☐ Conversion Term Insurance At Attained Age ☐ Partial Conversion Amount: $_____

☐ Surrender Balance ☐ Retain Balance

Select Product:

- ☐ Adjustable Life Legend
- ☐ Adjustable Life Summit
- ☐ Secure Whole Life
- ☐ Variable Adjustable Life Horizon
- ☐ Variable Adjustable Life Summit
- ☐ Other_____
- ☐ Accumlator Variable Universal Life
- ☐ Eclipse Indexed Universal Life
- ☐ Eclipse Protector Indexed Universal Life

(For Eclipse, Eclipse Protector, and Accumulator, select a Death Benefit Qualification Test. If none selected the default is GPT)

- ☐ Guideline Premium Test (GPT)
- ☐ Cash Value Accumulation Test (CVAT)

Select a Death Benefit or Dividend Option in Section I.
For Variable Adjustable Life and Universal Life, the default death benefit option is Level/Cash.
For Adjustable Life Legend, the default dividend option is Policy Improvement.
For Secure Whole Life, the default dividend option is Paid-Up Additions.

☐ Convert Term Insurance Into Existing Policy

Existing Policy Number:_____

☐ Convert Term Agreement

Term Agreement:_____ Insured Name:_____

Automatic Premium Loan (APL) Provision is automatically *added* at conversion, if available for the product, unless indicated here: ☐ Omit Automatic Premium Loan Provision

I. Other Adjustments

☐ Change Death Benefit Option To:

☐ Cash/Level ☐ Protection/Increasing ☐ Sum of Premiums

The Protection death benefit option generally requires underwriting. If changing from Level Death Benefit Option the face amount will decrease. To maintain current face amount check below (underwriting is required):

☐ Maintain Face Amount

☐ Change Dividend Option To:

_____

☐ Improve Risk Class

- ☐ Maintain current annual premium
- ☐ Reduce current annual premium

☐ Add Non-Smoker/Non-Tobacco Designation

1. Do you currently smoke any cigarettes or have you smoked any cigarettes in the past 12 months? ☐ Yes ☐ No
2. Do you currently use any tobacco or have you used any tobacco in the past 12 months? ☐ Yes ☐ No

I understand that a material misrepresentation, including but not limited to, statements regarding my tobacco status, may result in the cancellation of insurance and non-payment of any claim.

☐ Reinstate

I understand that this application will be attached to and considered part of the policy to which it applies. Also, I understand that this policy will be contestable, as to representations in this application, from the date of reinstatement for the time period stated in the incontestable provision of the policy.

J. Additional Agreements

Select only those agreements available on the products applied for.

☐ **Maintain** Current Annual Premium ☐ **Change** Current Annual Premium Accordingly

	ADD	REMOVE	DECREASE AMOUNT	NEW AMOUNT
Accidental Death Benefit Agreement*	☐	☐		
Additional Insured Agreement* (Complete Family Term Application)	☐	☐	☐	$_____
Adjustable Survivorship Life Agreement (Complete Application for Designated Life)	☐	☐	☐	$_____
Automatic Premium Loan Provision	☐	☐		
Business Continuation Agreement (Complete Application for Designated Life)	☐	☐	☐	$_____
Children's Term or Family Term Children's Agreement (Complete Family Term Application)	☐	☐	☐	$_____
Cost of Living Agreement	☐	☐		
Death Benefit Guarantee Agreement*	☐	☐		
Early Values Agreement*	☐			
Enhanced Guaranteed Agreement	☐	☐		
Enhanced Guaranteed Choice Agreement	☐	☐		
Estate Preservation Agreement*	☐	☐		
Face Amount Increase Agreement	☐	☐	☐	$_____
Family Term - Spouse Agreement (Complete Family Term Application)	☐	☐	☐	$_____
Guaranteed Insurability Option Agreement	☐	☐	☐	$_____
Guaranteed Insurability Option Agreement Waiver*	☐	☐		
Guaranteed Protection Waiver	☐	☐		
Interest Accumulation Agreement*	☐	☐	☐	_____%
Inflation Agreement	☐	☐		
Long-Term Care Agreement (Complete LTC Agreement Supplement Application)	☐	☐	☐	$_____
Overloan Protection Agreement	☐	☐		
Policy Enhancement Rider (Indicate a whole number from 3 to 10%)	☐	☐	☐	_____%
Single Premium Paid Up Additional Insured Agreement	☐	☐		
Surrender Value Enhancement Agreement*	☐	☐		
Term Insurance Agreement*	☐	☐		$_____
Waiver of Charges Agreement	☐	☐		
Waiver of Premium Agreement	☐	☐		
Other:_____				

**Can only be added when converting term insurance to a new policy.*

K. Life Insurance In Force and Replacement

Submit appropriate replacement forms (not needed if replacing group coverage).

Does the Insured have any life insurance or annuity in force or pending, including life insurance sold or assigned, or is in the process of being sold or assigned, to a life settlement, viatical or secondary market provider? If yes, provide details in the chart below. ☐ Yes ☐ No

Has there been, or will there be, replacement of any existing life insurance or annuity, as a result of this application? (Replacement includes, but is not limited to, a lapse, surrender, 1035 Exchange, loan, withdrawal, or other change to any existing life insurance or annuity.) If yes, provide details in the chart below. ☐ Yes ☐ No

Life Insurance In Force

Full Company Name	Amount	Year Issued	Type	Will it be Replaced?
			☐ Individual or ☐ Group ☐ Personal or ☐ Business	☐ Yes ☐ No
			☐ Individual or ☐ Group ☐ Personal or ☐ Business	☐ Yes ☐ No
			☐ Individual or ☐ Group ☐ Personal or ☐ Business	☐ Yes ☐ No

L. Insured Underwriting Information

Driver's license number	State of issue	Expiration date

Birthplace (state or, if outside the US, country)

Occupation	Income

1. Is the insured a US citizen? ☐ Yes ☐ No
   If no, citizen of _____
   Indicate visa type _____
2. Does the insured plan to travel or reside outside the US in the next two years? ☐ Yes ☐ No
   If yes, provide the city(s) and country(s), dates, length of stay, and purpose of travel:
   _____
   _____
3. Has the insured within the last five years, or does the proposed insured plan to engage in piloting a plane? If yes, complete the Military and Aviation Statement. ☐ Yes ☐ No
4. Has the insured within the last five years, or does the proposed insured plan to engage in sky diving, motor vehicle or boat racing, mountain/rock climbing, hang gliding, or underwater diving? If yes, complete the Sports and Avocation Statement. ☐ Yes ☐ No
5. Is the insured in the Armed Forces, National Guard, or Reserves? If yes, complete the Military and Aviation Statement. ☐ Yes ☐ No
6. Has the insured applied for insurance within the last six months? If yes, provide details below. ☐ Yes ☐ No
   _____
   _____
7. Has the insured applied for life insurance in the past five years that was declined or rated? If yes, provide details below. ☐ Yes ☐ No
   _____
   _____

	8. Has the insured, within the past ten years, been convicted of a driving while intoxicated violation, had a driver's license restricted or revoked, or been convicted of a moving violation? If yes, provide dates and details below. _____ _____	☐ Yes ☐ No
	9. Except for traffic violations, has the insured ever been convicted of a misdemeanor or felony? If yes, provide dates and details below. _____ _____	☐ Yes ☐ No
M. Additional Remarks		
N. Home Office Endorsements	**Home Office Corrections or Additions** Acceptance of the policy shall ratify changes entered here by Minnesota Life. Not to be used in IL, NJ, or OR for change in age, amount, classification, plan or benefits unless agreed to in writing.	

Individual Life Insurance
Life Receipt and Temporary Insurance Agreement

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

THIS IS TO BE LEFT WITH THE OWNER AT THE TIME MONEY IS TAKEN.

All premium checks must be made payable to Minnesota Life; do not make checks payable to the Representative and do not leave payee blank.

Money can not be accepted by the Representative if:

1. **the Proposed Insured has a history of heart disease, stroke, cancer, or diabetes,**
2. **the Proposed Insured has been rated or declined for life insurance in the past,**
3. **the application exceeds $1,000,000, or the total coverage inforce with Minnesota Life including this application exceeds $1,000,000.**

If you have paid our Representative at least the initial minimum premium for the policy you applied for, we will provide the following benefits:

TEMPORARY INSURANCE

In consideration of receiving your payment, we provide the following temporary insurance on the life of the Proposed Insured.

Temporary Accidental Death Insurance: We will pay the beneficiary the amount of life insurance applied for, or $10,000, whichever amount is less, if:

1. Part 1 of the application has been completed, and
2. the Proposed Insured's death results solely from an accidental injury and not as the result of suicide, and
3. this agreement has not terminated.

Temporary Life Insurance: We will pay the beneficiary the amount of life insurance you applied for (not including any Accidental Death Benefit applied for), or $250,000, whichever is less, if:

1. both Part 1 and Part 2 of the application have been completed, and
2. all representations on the Part 1 and Part 2 are true and complete, and
3. the Proposed Insured dies as the result of any cause other than suicide, and
4. this agreement has not terminated.

Termination of Temporary Insurance: The temporary insurance provided by this agreement will terminate on the earlier of:

1. 60 days after the date of this receipt, or
2. on the date we tender to you the policy applied for, or a policy other than as applied for, or a notice of rejection of the application.

THE INSURANCE APPLIED FOR

In determining whether we will issue the insurance applied for, we agree that if Part 1 and Part 2 of the application are fully completed and if all the representations are true and correct, we will determine the insurability of the Proposed Insured as of the date of the application. This means that when we determine the insurability of the Proposed Insured, we will not consider any change in health that occurs after the date of the application. The Proposed Insured's insurability will be determined at our Home Office according to our underwriting rules. We will have until the actual delivery of the policy to make this determination.

In no event will coverage exist under both this agreement and the policy or policies we offer you.

If you give us a check or draft which is not honored, this receipt and agreement shall be void.

Refund Conditions: We will refund the full amount of your premium payment, unless you accept delivery of the policy we offer or unless we pay a claim under the agreement.

Definitions: When we use the following words in the agreement this is what we mean.

"you", "your" - means the Owner.
"we", "our", "us" - means Minnesota Life Insurance Company, St. Paul, Minnesota 55101-2098.
"date of application" - means the date shown on Part 1 or Part 2 of the application or the date of this receipt, whichever date is later.
"beneficiary" - means the beneficiary or beneficiaries named in the application.

Representative's Authority: No Representative, including any medical examiner, has the authority to determine the insurability of the Proposed Insured, to waive the answer to any question contained in the application, to modify the application in any respect, or bind us by making any promise or representation other than as contained in this agreement.

Proposed insured name (last, first, middle)

Money paid by	Amount received **$**
Representative signature **X**	Date

Individual Life Insurance
Life Receipt and Temporary Insurance Agreement
For Joint Life Products

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

THIS IS TO BE LEFT WITH THE OWNER AT THE TIME MONEY IS TAKEN.

All premium checks must be made payable to Minnesota Life; do not make checks payable to the Representative and do not leave payee blank.

Money can not be accepted by the Representative if:

1. **either of the Proposed Insureds has a history of heart disease, stroke, cancer, or diabetes,**
2. **either of the Proposed Insureds has been rated or declined for life insurance in the past,**
3. **the application exceeds $1,000,000, or the total coverage inforce with Minnesota Life including this application exceeds $1,000,000.**

If you have paid our Representative at least one-twelfth of the annual premium for the policy you applied for, we will provide the following benefits:

TEMPORARY INSURANCE

In consideration of receiving your payment, we provide the following temporary insurance on the life of the Proposed Insureds, payable at the second death.

Temporary Life Insurance: We will pay the beneficiary the amount of life insurance you applied for (not including any Accidental Death Benefit applied for), or $250,000, whichever is less, if:

1. both Part 1 and Part 2 of both applications have been completed, and
2. all representations on the Part 1 and Part 2 of both applications are true and complete, and
3. neither the first or the second death occurs as the result of suicide, and
4. this agreement has not terminated.

Termination of Temporary Insurance: The temporary insurance provided by this agreement will terminate on the earlier of:

1. 60 days after the date of this receipt, or
2. on the date we tender to you the policy applied for, or a policy other than as applied for, or a notice of rejection of the application.

THE INSURANCE APPLIED FOR

In determining whether we will issue the insurance applied for, we agree that if Part 1 and Part 2 of both applications are fully completed and if all the representations are true and correct, we will determine the insurability of the Proposed Insureds as of the date of the applications. This means that when we determine the insurability of the Proposed Insureds, we will not consider any change in health that occurs after the date of the applications. Insurability of the Proposed Insureds will be determined at our Home Office according to our underwriting rules. We will have until the actual delivery of the policy to make this determination.

In no event will coverage exist under both this agreement and the policy or policies we offer you.

If you give us a check or draft which is not honored, this receipt and agreement shall be void.

Refund Conditions: We will refund the full amount of your premium payment, unless you accept delivery of the policy we offer or unless we pay a claim under the agreement.

Definitions: When we use the following words in the agreement this is what we mean.

"you", "your" - means the Owner.
"we", "our", "us" - means Minnesota Life Insurance Company, St. Paul, Minnesota 55101-2098.
"date of application" - means the date shown on Part 1 or Part 2 of the application or the date of this receipt, whichever date is later.
"beneficiary" - means the beneficiary or beneficiaries named in the application.

Representative's Authority: No representative, including any medical examiner, has the authority to determine the insurability of the Proposed Insureds, to waive the answer to any question contained in the application, to modify the application in any respect, or bind us by making any promise or representation other than as contained in this agreement.

Proposed insured name (last, first, middle)

Proposed insured name (last, first, middle)

Money paid by	Amount received **$**
Representative signature **X**	Date

Individual Life Insurance
Home Office Corrections or Additions

Minnesota Life Insurance Company - A Securian Company
Life New Business ● 400 Robert Street North ● St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

The following Home Office Corrections or Additions were requested on _____ to Policy Number: _____ and should be attached to the contract. Acceptance of the policy shall ratify changes entered here by Minnesota Life. Not to be used in IL, NJ, or OR for change in age, amount, classification, plan or benefits unless agreed to in writing.

Date	Assistant Secretary signature X

Individual Life Insurance Application Part 1

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

A. Proposed Insured Information

Proposed insured name (last, first, middle)

Social Security number	Date of birth (month, day, year)	Gender ☐ Male ☐ Female

Driver's license number	Issue state	Expiration date

Primary telephone number	Secondary telephone number

Birthplace (state or, if outside the US, country)	E-mail address

Street address (no P.O. Box)	City	State	Zip code

Occupation	Years in occupation	Income	Net worth

B. Product

Product applied for	Base face amount $

Total annual planned premium	Plan of insurance (if applicable)

Death benefit qualification test (if applicable, defaults to GPT if none selected)
☐ Guideline Premium Test (GPT) ☐ Cash Value Accumulation Test (CVAT)

Death benefit option (defaults to Cash/Level if none selected)
☐ Cash/Level ☐ Protection/Increasing ☐ Sum of Premiums

Dividend option (if applicable, defaults to Paid-Up Additions for Secure)

C. Additional Benefits and Agreements

☐ Accelerated Benefit Agreement
(Submit ABA Outline of Coverage form)
☐ Accidental Death Benefit Agreement
☐ Additional Insurance Agreement
$_____
☐ Children's Term or Family Term Agreement
(Submit Family Term Application)
☐ Death Benefit Guarantee Agreement
☐ Early Values Agreement
☐ Estate Preservation Agreement
$_____
Face Amount (Not to exceed 122% of base amount)

☐ Guaranteed Insurability Option Agreement
$_____

☐ Guaranteed Insurability Option Agreement Waiver
$_____
☐ Long-Term Care Agreement
(Submit LTCA Supplemental Application)
☐ Overloan Protection Agreement
☐ Single Premium Paid-Up Additional Insurance Agreement
☐ Surrender Value Enhancement
☐ Term Insurance Agreement
$_____
☐ Waiver of Charges Agreement
☐ Waiver of Premium Agreement
☐ Other
_____
☐ Other
_____

THE FOLLOWING BENEFITS AND AGREEMENTS *WILL BE ADDED* IF AVAILABLE FOR YOUR POLICY, UNLESS YOU CHOOSE TO OMIT THEM:

☐ Omit Automatic Premium Loan Provision

D. Special Dating

☐ Date to save age
☐ Specific date (month/day/year): _____ (cannot select 29th, 30th, or 31st of the month)

Are there any other Minnesota Life applications associated with this application? ☐ Yes ☐ No

If yes, please provide Proposed Insured(s) full name(s) and whether the policies should have the same issue date.

E. Life Insurance In Force and Replacement

Submit appropriate replacement forms (not needed if replacing group coverage).

Does the Proposed Insured have any life insurance or annuity in force or pending, including life insurance sold or assigned, or is in the process of being sold or assigned, to a life settlement, viatical or secondary market provider? If yes, provide details in the chart below. ☐ Yes ☐ No

Has there been, or will there be, replacement of any existing life insurance or annuity, as a result of this application? (Replacement includes, but is not limited to, a lapse, surrender, 1035 Exchange, loan, withdrawal, or other change to any existing life insurance or annuity.) If yes, provide details in the chart below. ☐ Yes ☐ No

Life Insurance In Force

Full Company Name	Amount	Year Issued	Type	Will it be Replaced?
			☐ Individual or ☐ Group ☐ Personal or ☐ Business	☐ Yes ☐ No
			☐ Individual or ☐ Group ☐ Personal or ☐ Business	☐ Yes ☐ No
			☐ Individual or ☐ Group ☐ Personal or ☐ Business	☐ Yes ☐ No

F. Beneficiary Information

If the beneficiary is a trust, give complete trust name and date trust established.

	Beneficiary First and Last Name	Relationship to Proposed Insured	SSN/TIN (If known)
Primary			
Contingent			

G. Owner Information

Submit the appropriate trust, corporate, or non-corporate form(s).

Only complete this section if the Owner is different than the Insured.

Owner name (last, first, middle)

☐ Individual
☐ Trust (submit Certification of Trustee Authority form)
☐ Corporate (submit Corporate/Non-Profit Resolution and Employer Notification Regarding the Potential Taxation of Death Benefit forms)
☐ Partnership (submit Partnership/LLC Resolution and Employer Notification Regarding the Potential Taxation of Death Benefit forms)
☐ Other_____

Social Security or tax ID number	Date of birth or trust date
Street address (no P.O. box)	

City	State	Zip code
Relationship to proposed insured	Telephone number	
E-mail address		

H. Premium and Billing Information

Premium Notice Should Be Sent To:

☐ Proposed Insured Address in Section A ☐ Owner Address in Section G
☐ Owner's Business/Employer Address (Indicate below) ☐ Other (Indicate below)

Name

Address

City | State | Zip code

Payment Method:

☐ Annual ☐ Quarterly
☐ Semi-Annual ☐ Monthly Electronic Funds Transfer (EFT) Plan Number _____
(If new plan, submit EFT/APP Authorization)

☐ List Bill Plan Number _____ (if new plan, submit List Bill Setup form)

Third Party Notification (optional):
If you wish, you may give us the name and address of a person whom you designate to also receive notice of an overdue premium or pending lapse. (Indicate below)

Name

Address

City | State | Zip code

I. Additional Premium

Universal Life Additional Premium (excluding 1035)

$_____

1035 Exchange ☐ Yes ☐ No
(If yes, submit 1035 Exchange Agreement form)

J. Money Submitted with Application

Make all checks payable to Minnesota Life.

Has the Owner paid money with this application to the representative? ☐ Yes ☐ No
If yes, amount: $_____

Was a Life and Temporary Insurance Agreement given? ☐ Yes ☐ No

K. Special Mailing Address

If mail (other than the premium notice) should be sent somewhere other than the Owner's Home Address, please indicate here.

☐ Owner's Business Address
☐ Other - Indicate Name and Address

Name (last, first, middle)

Address

City | State | Zip code

L. Request for Illustration

Complete for non-variable products, excluding Advantage Elite 5-30.

Choose one of the following:

☐ An illustration matching the policy applied for was presented to the Owner/Applicant and a signed copy is included with this application. The Owner/Applicant has received a copy.

☐ An illustration was presented or provided to the Owner/Applicant, but is different from the policy applied for. An illustration conforming to the policy as issued will be provided to the Owner/Applicant no later than at the time of policy delivery.

☐ No illustration conforming to the policy as applied for was shown or provided to the Owner/Applicant prior to or at the time of taking this application. An illustration conforming to the policy as issued will be provided to the Owner/Applicant no later than at the time of policy delivery.

M. Proposed Insured Underwriting Information

1. Is the proposed insured a US citizen? ☐ Yes ☐ No

   If no, citizen of _____

   Indicate visa type _____

2. Does the proposed insured plan to travel or reside outside the US in the next two years? ☐ Yes ☐ No
   If yes, provide the city(s) and country(s), dates, length of stay, and purpose of travel:

   _____

   _____

3. Has the proposed insured within the last five years, or does the proposed insured plan to engage in piloting a plane? If yes, complete the Military and Aviation Statement. ☐ Yes ☐ No

4. Has the proposed insured within the last five years, or does the proposed insured plan to engage in sky diving, motor vehicle or boat racing, mountain/rock climbing, hang gliding, or underwater diving? If yes, complete Sports and Avocation Statement. ☐ Yes ☐ No

5. Is the proposed insured in the Armed Forces, National Guard, or Reserves? If yes, complete Military and Aviation Statement. ☐ Yes ☐ No

6. Has the proposed insured applied for insurance within the last six months? If yes, provide details below. ☐ Yes ☐ No

   _____

   _____

7. Has the proposed insured applied for life insurance in the past five years that was declined or rated? If yes, provide details below. ☐ Yes ☐ No

   _____

   _____

8. Has the proposed insured, within the past ten years, been convicted of a driving while intoxicated violation, had a driver's license restricted or revoked, or been convicted of a moving violation? If yes, provide dates and details below. ☐ Yes ☐ No

   _____

   _____

9. Except for traffic violations, has the proposed insured ever been convicted of a misdemeanor or felony? If yes, provide dates and details below. ☐ Yes ☐ No

   _____

   _____

10. Will the Proposed Owner and/or beneficiary, and/or any entity on the Proposed Owner's behalf, receive any compensation, whether via the form of cash, property, an agreement to pay money in the future, a percentage of the death benefit, or otherwise if this policy is issued? ☐ Yes ☐ No

11. Has the Proposed Owner been involved in any discussion about the possible sale or assignment of this policy or a beneficial interest in a trust, LLC, or other entity created on the owner's behalf? If yes, provide details and a copy of the applicable entity's controlling documents. ☐ Yes ☐ No

    _____

    _____

12. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? If yes, submit the Premium Financing Advisor Attestation and Premium Financing Client Disclosure forms. ☐ Yes ☐ No

13. Have you had a life expectancy report or evaluation done by an outside entity or company? If yes, please explain why the expectancy report was obtained. ☐ Yes ☐ No

    _____

    _____

N. Additional Remarks	
O. Home Office Endorsements	**Home Office Corrections or Additions** Acceptance of the policy shall ratify changes entered here by Minnesota Life. Not to be used in IL, NJ, or OR for change in age, amount, classification, plan or benefits unless agreed to in writing.

Individual Life Insurance
Beneficiary Change Acknowledgement

Minnesota Life Insurance Company - A Securian Company
Individual Policyowner Services • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

XXXXXXXXXX

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Policy Number: XXXXXXXX
Insured(s): X X

The following beneficiary has been recorded, as you authorized. This revokes all prior beneficiary designations. Please take a moment to verify the accuracy of this information and contact us at 1-800-649-5726 if any corrections are needed.

If more than one class of beneficiary is designated, the class number determines the order in which beneficiaries become eligible to receive death proceeds. Surviving beneficiaries in the same class share equally unless otherwise specified. "Children" used without modification, includes only lawful bodily issue of first generation and legally adopted persons. Right is reserved to revoke and change any beneficiary not designated Irrevocable. Any policy provisions requiring policy endorsement is waived. This acknowledgement, by the Company at its Home Office, is in lieu of endorsement.

Dennis E. Prokopakey
Secretary

Class 1: X

Class 2: X

Class 3: X

Class 4: X

Class 5: X

FOR HOME OFFICE USE ONLY

Date recorded	Minnesota Life Insurance Company
XXXXXXXXXX	By , Registrar

ATTACH THIS ACKNOWLEDGEMENT TO YOUR POLICY

Individual Life Insurance
Financial Supplement to Application

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Name of proposed insured | Date of birth

Application number

SECTION A - PURPOSE OF INSURANCE (select all that apply)

1. ☐ Personal (**Complete Section B**)
   - ☐ Income replacement
   - ☐ Estate planning
   - ☐ Other (specify) _____

2. ☐ Business (**Complete Sections B** *and* **C**)
   - ☐ Key person
   - ☐ Stock repurchase
   - ☐ Buy-sell
   - ☐ Creditor amount of loan $ _____

Is insurance required by the creditor? ☐ Yes ☐ No

3. How was the amount of insurance arrived at? _____

SECTION B - PERSONAL INFORMATION

If a joint policy is being applied for, complete questions 4 through 6 jointly for both proposed insureds.

4.	Estimated Current Year	Past Year		Estimated Current Year	Past Year
ANNUAL INCOME					
Earned Income			**ASSETS**		
Annual Salary or Wages	$	$	Cash	$	$
Bonuses	$	$	Real Estate	$	$
Other Earned Income	$	$	Stocks & Bonds	$	$
Total Earned Income	$	$	Autos	$	$
			Personal	$	$
Unearned Income			Business Equity	$	$
Dividends & Interest	$	$	Other	$	$
Net Real Estate Income	$	$	**Total Assets**	$	$
Other	$	$			
Total Unearned Income	$	$	**LIABILITIES**		
			Mortgages	$	$
			Business	$	$
			All other personal	$	$
TOTAL ANNUAL INCOME	$	$	**Total Liabilities**	$	$

5. Estimated Net Worth $ _____

6. Any bankruptcies in the past 7 years? If yes, give type and details. ☐ Yes ☐ No _____

SECTION C - BUSINESS INFORMATION

7. Business name and year established _____

8. Type of business ☐ Sole proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Corporation

9. Nature of business _____

10. Percent of business owned by first proposed insured? _____ %

11. Are other owners or key employees insured or being insured? ☐ Yes ☐ No Give details and breakdown of ownership percentage for each: _____

12. Business Financials:

	Estimated Current Year	Past Year
Assets		
Liabilities		
Net Worth		
Gross Sales		
Net Income		

13. Estimated fair market value of business? _____

SIGNATURES

I certify that I have read the above questions and answers and declare that all statements and answers to the above questions are true and complete as recorded.

Witness	Signature of proposed insured	Date
X	X	

Individual Life Insurance Application 1A

[**Minnesota Life Insurance Company** - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098]

[MINNESOTA LIFE]

Section A: Proposed Insured Information

Proposed insured name (last, first, middle)

Social Security number | Income | Net worth

Date of birth (mm/dd/yyyy) | Gender ☐ Male ☐ Female

Primary telephone number | Secondary telephone number

Section B: Owner Information - *Complete if Owner is not the Proposed Insured. Submit entity owner forms when appropriate.*

Owner name (last, first, middle)

Date of birth/trust (mm/dd/yyyy) | Social Security number or tax ID no.

Relationship to proposed insured | Primary telephone number

☐ Individual ☐ Trust ☐ Corporate ☐ Partnership
☐ Other _____

Section C: Products and Additional Agreements - *Only select agreements applicable to the chosen product*

Product applied for

Base face amount

UNIVERSAL LIFE ONLY

Total annual planned premium

Additional premium (exclude 1035 funds)

Death benefit option (select one):
☐ Level
☐ Increasing
☐ Sum of Premiums

Death Benefit Qualification Test (select one):
☐ Guideline Premium Test (GPT)
☐ Cash Value Accumulation Test (CVAT)

WHOLE LIFE ONLY

Additional premium (exclude 1035 funds)

Dividend Option (select one):
☐ Accumulations
☐ Cash
☐ Paid Up Additional (default if none selected)
☐ Reduce Premium, Balance to Cash
☐ Reduce Premium, Balance to Paid Up Additions
☐ Loan Repay with Balance to Cash
☐ Loan Repay with Balance to Paid Up Additions

Unless omitted, Automatic Premium Loan Provision will be added to the policy:
☐ Omit Automatic Premium Loan Provision

AGREEMENTS APPLIED FOR:

☐ Accelerated Benefit Agreement (Submit ABA Outline of Coverage form)
☐ Accidental Death Benefit Agreement Coverage Amount: _____
☐ Additional Insurance Agreement Coverage Amount: _____
☐ Children's Term Agreement (Submit Family/Children's Term Application) Coverage Amount: _____
☐ Death Benefit Guarantee Agreement
☐ Early Values Agreement
☐ Family Term Agreement - Child (Submit Family/Children's Term Application) Coverage Amount: _____
☐ Guaranteed Insurability Option Agreement Coverage Amount: _____
☐ Guaranteed Insurability Option Agreement with Waiver Agreement Coverage Amount: _____
☐ Overloan Protection Agreement
☐ Single Premium Paid Up Additional Insurance Agreement
☐ Surrender Value Enhancement Agreement
☐ Term Insurance Agreement Coverage Amount: _____
☐ Waiver of Charges
☐ Waiver of Premium
☐ Other: _____
☐ Other: _____

Section D: Beneficiary Information - *If beneficiary is a trust, complete trust name & date trust established*

	Beneficiary First and Last Name	Relationship to Proposed Insured	SSN/TIN (If known)
Primary			
Contingent			

Section E: Life Insurance in Force and Replacement

Does the Proposed Insured have any life insurance or annuity in force or pending, including life insurance sold or assigned to, or is in the process of being sold or assigned to, a life settlement, viatical or secondary market provider?

☐ Yes ☐ No

If yes, complete the *In Force Coverage and Replacement Chart*.

Has there been, or will there be, replacement of any existing life insurance or annuity as a result of this application? (Replacement includes, but is not limited to, a lapse, surrender, 1035 Exchange, loan, withdrawal, or other change to any existing life insurance or annuity.)

☐ Yes ☐ No

If yes, submit state replacement forms. (NOTE: State replacement forms are not required when replacing group coverage, except in FL, MI, and WA.)

1035 Exchange? ☐ Yes ☐ No

If yes, also submit the 1035 Exchange Agreement form.

In Force Coverage and Replacement Chart

Full Company Name & Policy Number	Face Amount	Year Issued	Type	Replacing?
			☐ Individual or ☐ Group ☐ Personal or ☐ Business	☐ Yes ☐ No
			☐ Individual or ☐ Group ☐ Personal or ☐ Business	☐ Yes ☐ No
			☐ Individual or ☐ Group ☐ Personal or ☐ Business	☐ Yes ☐ No

Section F: Specific Policy Date Request

Are there any other Minnesota Life applications associated with this application?

☐ Yes ☐ No

If yes, provide proposed insured(s) full name(s) and whether the policies should have the same issue date

☐ Date to save age ☐ Specific date (mm/dd/yyyy): _____ (cannot select 29th, 30th, or 31st of month)

Section G: STOLI and Premium Financing

1. Will the Proposed Owner and/or beneficiary, and/or any entity on the Proposed Owner's behalf, receive any compensation, whether via the form of cash, property, an agreement to pay money in the future, a percentage of the death benefit, or otherwise if this policy is issued? ☐ Yes ☐ No

2. Has the Proposed Owner been involved in any discussion about the possible sale or assignment of this policy or beneficial interest in a trust, LLC, or other entity created on the Owner's behalf? If yes, provide details and a copy of the applicable entity's controlling documents: ☐ Yes ☐ No

_____

_____

3. Is this policy being funded via a premium financing loan or with funds borrowed, advanced, or paid from another person or entity? If yes, submit the Premium Financing Advisor Attestation and Premium Financing Client Disclosure forms ☐ Yes ☐ No

4. Have you had a life expectancy report or evaluation done by an outside entity or company? If yes, please explain why the expectancy report was obtained. ☐ Yes ☐ No

_____

_____

Section H: Request for Illustration - *Not required for variable or term products*

Please choose one of the following:

☐ An Illustration was signed and matches the policy applied for. A copy is included with this application and a copy has been left with the applicant.

☐ An illustration was shown or provided, but is different from the policy applied for. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

☐ No illustration conforming to the policy as applied for was shown or provided prior to or at the time of this application. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

Section I: Money Submitted

Has the owner paid money with this application 1A to the representative? ☐ Yes ☐ No	If yes, amount **$**

Was a life receipt and temporary insurance agreement given? ☐ Yes ☐ No

Section J: Authorization, Agreements, and Signatures

AGREEMENTS: I have read, or had read to me the statements and answers recorded on this Application 1A. They are given to obtain this insurance and are, to the best of my knowledge and belief, true and complete and correctly recorded. I understand that any false statement or misrepresentation on this Application 1A and the Application 1B may result in loss of coverage under this policy subject to the incontestability provision. I agree that they will become part of this Application 1A and the Application 1B and any policy issued on it. The insurance applied for will not take effect unless the policy is issued and delivered and the full first premium is paid while the health of the Proposed Insured remains as stated in the application. **If such conditions are met, the insurance will take effect as of the earlier of the Policy Date specified in the policy or the date the policy is delivered to me; the only exception to this is provided in the Life Receipt and Temporary Insurance Agreement, issued if the premium is paid in advance.**

VARIABLE LIFE: **I understand that the amount or the duration of the death benefit (or both) of the policy applied for may increase or decrease depending on the investment results of the sub-accounts of the separate account. I understand that the actual cash value of the policy applied for is not guaranteed and increases and decreases depending on the investment results. There is no minimum actual cash value for the policy values invested in these sub-accounts.**

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, clinic or other health care provider, insurance or reinsuring company, consumer reporting agency, the Medical Information Bureau, Inc. (MIB), or employer which has any records or knowledge of my physical or mental health, and/or the physical or mental health of each minor child listed as the Proposed Insured, to give all such information and any other non-medical information relating to such persons to Minnesota Life Insurance Company or its reinsurers. This shall include ALL INFORMATION as to any medical history, consultations, diagnoses, prognoses, prescriptions or treatments and tests, including information regarding alcohol or drug abuse and AIDS or AIDS-related conditions. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by Minnesota Life Insurance Company to collect and transmit such information.

I understand this information is to be used for the purpose of determining eligibility for insurance and may be used for determining eligibility for benefits. I understand this information may be made available to Underwriting, Claims, support staff, licensed representatives and firms of Minnesota Life. I authorize Minnesota Life Insurance Company or its reinsurers to release any such information to reinsuring companies, the MIB, or other persons or organizations performing business or legal services in connection with my Application 1A and Application 1B, claim or as may be otherwise lawfully required or as I may further authorize.

I agree this Authorization shall be valid for twenty-four months from the date it is signed. I may revoke this Authorization at any time by sending a written request addressed to the Individual Underwriting Department, Minnesota Life Insurance Company, 400 Robert Street North, St. Paul, MN 55101-2098.

I understand that I, or my legal representative, have the right to request and receive a copy of this Authorization and that a photocopy of this Authorization shall be as valid as the original. I understand that no sales represenattive has the company's authorization, to accept risk, pass on insurability, or make, or void, waive or change any conditions or provisions of the application, policy or receipt, as applicable;

I acknowledge that I have been given the Your Privacy Is Important To Us notice.

FRAUD WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be guilty of a criminal offense and subject to penalties under state law.

Proposed insured signature **X**	City	State	Date
Parent/conservator/guardian signature (juvenile applications) **X**	City	State	Date
Owner signature (required if other than proposed insured; give title if signed on behalf of a business) **X**	City	State	Date

I believe that the information provided by this Applicant is true and accurate. I certify I have accurately recorded all information given by the Proposed Insured(s).

Licensed representative signature **X**	Date	Business telephone number	Firm/rep code

Individual Life Insurance Application 1B

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Section A: Proposed Insured Information

Driver's license number	Issue state	Expiration date	Occupation	Years in occupation

Street address (no P.O. Box)	City	State	Zip code

Email address

1. Birthplace (state or, if outside the U.S., country) _____
2. Is the Proposed Insured a U.S. citizen? If no, citizen of _____ ☐ Yes ☐ No
   Visa type _____
3. Does the Proposed Insured plan to travel or reside outside the U.S. in the next two years? ☐ Yes ☐ No
   (If yes, complete the Foreign Residence and Travel Questionnaire.)
4. Has the Proposed Insured within the last five years, or does the Proposed Insured plan to engage in piloting a plane? (If yes, complete the Military/Aviation Statement.) ☐ Yes ☐ No
5. Has the Proposed Insured within the last five years, or does the Proposed Insured plan to engage in sky diving, motor vehicle or boat racing, mountain/rock climbing, hang gliding, or underwater diving? (If yes, complete the Sports/Avocation Statement.) ☐ Yes ☐ No
6. Is the Proposed Insured in the the Armed Forces, National Guard, or Reserves? ☐ Yes ☐ No
   (If yes, complete the Military/Aviation Statement.)
7. Has the Proposed Insured applied for insurance within the last six months? ☐ Yes ☐ No
   If yes, provide details:
   _____
8. Has the Proposed Insured applied for life insurance in the past five years that was declined or rated? If yes, provide details: ☐ Yes ☐ No
   _____
9. Has the Proposed Insured, within the past ten years, been convicted of a 'driving while intoxicated' violation, had a driver's license restricted or revoked, or been convicted of a moving violation? If yes, provide dates and details: ☐ Yes ☐ No
   _____
10. Except for traffic violations, has the Proposed Insured ever been convicted of a misdemeanor or felony? If yes, provide dates and details: ☐ Yes ☐ No
    _____

Section B: Owner Information - *Complete if Owner is not the Proposed Insured*

Street address (no P.O. Box)	City	State	Zip code

Email address

Section C: Premium and Billing Information - *Selecting a third party addressee is optional*

Payment method:
☐ New Monthly Electronic Funds Transfer (submit APP/EFT Authorization)
☐ Quarterly ☐ Semi-annual ☐ Annual
☐ Other (credit card payments not accepted) _____

Premium notice should be sent to:
☐ Proposed insured address in Section A
☐ Owner address in Section B
☐ Other (complete payer information)

☐ Overdue premium or pending lapse notice should also be sent to a third party addressee (complete third party addressee information)

Payer or third party addressee name	Address	City	State	Zip code

Section D: Mailing Address - *Complete if mail (other than the premium notice) should be sent elsewhere than the Owner's address in Section B.*

Mail recipient name	Address	City	State	Zip code

Section E: Home Office Endorsement

Acceptance of the policy shall ratify changes entered here by Minnesota Life. Not to be used in IL, NJ, or OR for change in age, amount, classification, plan, or benefits unless agreed to in writing.

Section F: Additional Information

Section G: Home Office Endorsement

I have read the statements and answers recorded on this Application 1B; they are to the best of my knowledge and belief true, complete and correctly recorded. I agree that they will become part of my application and any policy issued on it.

Proposed insured signature **X**	Date
Representative signature (witness) **X**	Date

Supplemental Information to the Application for Life Insurance

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Proposed primary insured name	Social Security number

ADDITIONAL INFORMATION

Dated at _____ this _____ day of _____, _____
City State Month Year

Signature of proposed insured	Signature of proposed owner (if other than proposed insured)
X	X
Signature of parent or legal guardian (if proposed insured is underage)	Signature of additional insured
X	X
Signature of agent	
X	

Individual Life Insurance
Life Receipt and Temporary Insurance Agreement

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
Life Policy Administration • 400 Robert Street North • St. Paul, Minnesota 55101-2098

THIS IS TO BE LEFT WITH THE OWNER AT THE TIME MONEY IS TAKEN.

All premium checks must be made payable to Minnesota Life; do not make checks payable to the Representative or leave payee blank.

Money can not be accepted by the Representative if:

1. **the Proposed Insured has a history of heart disease, stroke, cancer, or diabetes,**
2. **the Proposed Insured has been rated or declined for life insurance in the past,**
3. **the application exceeds $1,000,000, or the total coverage in force with Minnesota Life including this application exceeds $1,000,000.**

TEMPORARY LIFE INSURANCE

In consideration of receiving your payment and subject to the following conditions, we provide a Temporary Life Insurance benefit on the life of the Insured.

- If you are reinstating a policy, the temporary life insurance will equal the amount of insurance which you have asked to reinstate, or $250,000, whichever is less.
- If you are applying for a policy change which increases the face amount of your policy, the temporary life insurance will equal the increased face amount or $250,000, whichever is less.

Conditions
We will provide the benefits listed above if the following conditions are met:

1. Both the Policy Change Application Part 1 and Part 2 have been completed, and
2. All the representations on the Part 1 and Part 2 are true and complete, and
3. The insured dies as the result of any cause other than suicide, and
4. This agreement has not terminated.

If these conditions are satisfied, we will determine the insurability of the insured as of the date of application, and will not consider any change in health that occurs after that date. We will have until the actual delivery of the policy to make this determination.

Termination of Temporary Life Insurance
The temporary life insurance provided by this agreement will terminate on the earlier of:

1. 60 days after the date of this receipt, or
2. The date we tender you the policy applied for, or a policy other than applied for, or a notice of our rejection of your application.

In no event will coverage exist under both this agreement and the policy resulting from the reinstatement or policy change.

If you give us a check or draft which is not honored, this receipt and agreement shall be void.

Refund Conditions: We will refund the full amount of your premium payment, unless you accept delivery of the policy we offer or unless we pay a claim under this agreement.

Definitions: When we use the following words in the agreement this is what we mean.

“you”, “your” - means the Owner.
“we”, “our”, “us” - means Minnesota Life Insurance Company, St. Paul, Minnesota 55101-2098.
“date of application” - means the date of the Change Request, Policy Change Application Part 1 or Part 2, or the date of this receipt, whichever date is latest.
“beneficiary” - means the beneficiary or beneficiaries named in the policy.

Representative’s Authority: No Representative, including any medical examiner, has the authority to determine the insurability of the Proposed Insured, to waive the answer to any question contained in the application, to modify the application in any respect, or bind us by making any promise or representation other than as contained in this agreement.

Insured name (last, first, middle)	Policy number
Money paid by	Amount received **$**
Representative signature **X**	Date

Individual Life Insurance Application Part 2

MINNESOTA LIFE

Minnesota Life Insurance Company - A Securian Company
Life New Business • 400 Robert Street North • St. Paul, Minnesota 55101-2098

Proposed insured name (last, first, middle)	Date of birth

Height and weight	Change in past year	Cause of weight gain or loss
FT. IN. LBS.	LBS. ☐ GAIN ☐ LOSS	

		Yes	No
1.	A. Have you ever smoked cigarettes?	☐	☐

Current smoker	Past smoker	Packs per day	Date last cigarette smoked (mm, dd, yy)
☐	☐		

B. Have you ever used tobacco, other than cigarettes, in any form?			☐	☐

What type	Current user	Past user	How much	Date of last use (mm, dd, yy)
	☐	☐		

2.	Are you taking or do you take any prescription or non-prescription medications or drugs?	☐	☐
3.	During the past 10 years have you had or been treated for:		
	A. Seizures; epilepsy; paralysis; fainting spells; headaches; dizziness; sleep disorder; or any other disorder of the brain or nervous system?	☐	☐
	B. Depression; stress; anxiety; nervousness; nervous breakdown; or any other nervous, mental, or emotional disorder?	☐	☐
	C. High blood pressure; chest pain; chest discomfort or tightness; heart attack; heart murmur; stroke; irregular heart beat; or any other disease or disorder of the heart or blood vessels?	☐	☐
	D. Asthma; shortness of breath; bronchitis; pneumonia; emphysema; chronic cough; or any other lung or respiratory disorder?	☐	☐
	E. Abdominal pain; ulcer; colitis; cirrhosis; hepatitis; recurrent diarrhea; intestinal bleeding; or any other disease of the liver, gallbladder, pancreas, stomach, or intestines?	☐	☐
	F. Kidney stone; protein, sugar, blood or blood cells in the urine; or any disorder of the urinary tract, bladder or kidneys?	☐	☐
	G. Disorder or abnormality of the prostate, uterus, ovaries, or breasts; pregnancy complication; testicular disease; genital herpes, syphilis, gonorrhea, or other sexually transmitted disease?	☐	☐
	H. Diabetes; thyroid disorder; lymph node enlargement; skin disorder; or disorder of any other glands?	☐	☐
	I. Cancer; tumor; or cyst?	☐	☐
	J. Anemia, leukemia, or other blood disorder?	☐	☐
	K. Back or neck pain; spinal strain or sprain; sciatica; arthritis; gout; carpal tunnel syndrome; or any bone, joint, or muscle disorder?	☐	☐
	L. Disorder of the eyes, ears, nose or throat?	☐	☐
	M. Any physical deformity or defect?	☐	☐
	N. Any immune deficiency disorder including AIDS or AIDS-Related Complex (ARC), or AIDS-related conditions?	☐	☐
	O. A blood test showing evidence of antibodies to the AIDS (HIV) virus?	☐	☐
	P. Any chronic or recurrent fever, fatigue or viral illness?	☐	☐
4.	Do you consume alcoholic beverages? If yes, what kinds, how much and how often?	☐	☐
5.	During the past 10 years:		
	A. Have you been advised to limit the use of alcohol or drugs; sought or received treatment, advice, or counseling for alcohol or drugs; or joined a group because of alcohol or drug use?	☐	☐
	B. Have you tried or used cocaine, heroin, marijuana, barbiturates or other controlled substances?	☐	☐

	Yes	No
6. Other than above, have you in the past five years:		
A. Consulted or been advised to consult a physician, psychiatrist, psychologist, therapist, counselor, chiropractor, or other health care practitioner? (Include regular check-ups.)	☐	☐
B. Had a check-up, illness, or surgery, or been treated or evaluated at a hospital or any other health care facility?	☐	☐
C. Had an EKG, x-ray, stress test, echocardiogram, angiography, blood studies or any other diagnostic test?	☐	☐
D. Been advised to have any test, hospitalization, or surgery which was not completed?	☐	☐

7. Family History: Make a note of diabetes, cancer, melanoma, heart, and kidney disease.

		Age(s)	Health History		Age(s)	Cause of Death
Father	Living			Deceased		
Mother						
Siblings						
Siblings						

8. Do you have a personal physician or belong to an H.M.O. or clinic? If so, please provide information below. ☐ ☐

Name	Phone number	
Street address		
City	State	Zip code
Date last seen	Reason	

Give details of all yes answers, *including doctors' names, addresses and dates.*

I have read the statements and answers recorded on this Application Part 2; they are to the best of my knowledge and belief true, complete and correctly recorded. I agree that they will become part of this application and any policy issued on it.

Proposed insured signature

X

Witness	Date

SERFF Tracking Number:	*MNNL-126770349*	*State:*	*Arkansas*
Filing Company:	*Minnesota Life Insurance Company*	*State Tracking Number:*	*46510*
Company Tracking Number:	*MHC-999*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Applications*		
Project Name/Number:	*Individual Life Applications/MHC-999*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

Certification of Compliance.pdf

Item Status: **Status Date:**

Satisfied - Item: Description of IPipeline Process

Comments:

Attached is E-Signature Process Description.

Attachment:

E-Signature Process Descrip.pdf

CERTIFICATION OF COMPLIANCE

Minnesota Life Insurance Company certifies that it has reviewed and is in compliance with the following Arkansas Rules and Regulations and Statutes.

Rule and Regulation 19	Unfair Sex Discrimination
Rule and Regulation 49	Guaranty Association Notice
Arkansas Statute 23-80-206	Flesch Certification
Arkansas Statute 23-79-138	Contact Notice

Digitally signed by Matthew Harrington, Assistant Secretary
DN: cn=Matthew Harrington, Assistant Secretary, o=Minnesota Life Insurance Company, ou=Law, email=matthew.harrington@securian.com, c=US
Location: Minnesota Life Insurance Company
Date: 2010.08.16 13:00:02 -05'00'

Name: Matthew Harrington

Title: Assistant Secretary

Date: August 16, 2010

Minnesota Life Insurance Company

Client E-Signature Process

Minnesota Life will be using *iPipeline* as the vendor that will facilitate capturing our E-Signature. This vendor has set up secure electronic application processing for several other insurance companies. The process that will be followed is below:

1. The licensed advisor who made the sale of the life insurance product will send the client an email. Within this email is a secured link that the client will click. This link will bring them to a secured website.
2. Once in the secured website that client will need to verify the last four digits of their social security number in order to access the E-Signature process.
3. Once the last four digits of the SSN is confirmed, the client will still be in the secured website and will have access to E-Sign their application.
4. The first screen the client will see will ask them to "elect in" to the E-Signature process, at this time the client has the ability to select "no" and state they do not want to use E-Signature. If they select no, a confirmation screen will be presented to them giving them a button to confirm they do not want to proceed.
5. If the client elects to proceed and use the E-Signature process, they are then asked to read the "Terms and Conditions and Electronic Signature Consent" screen
6. They must click an "accept" button to confirm they have read the screen.
7. After they have confirmed they have read the document they can then proceed to viewing their application.
8. Once they have viewed the information on the application, they are given the opportunity to correct any information displayed by contacting the advisor.
9. If they have no changes, they then are asked to proceed to signing the application electronically.
10. Again, at this time the client is given the option to opt out of this electronic process.
11. If they select to proceed, the client is asked again to verify the last 4 digits of their Social Security Number and then they are allowed to E-Sign the application.
12. Once the E-Signature has taken place the client is then allowed to reopen the application and review the final application with their E-Signature. It is at this time that the client can choose to print and/or save a copy of their application.